October, 1954

Canadian Hospital

- *What of the Night?*
- *Nora-Frances Henderson Hospital*
- *Labour problems in hospital administration*
- *Setting the Stage for community assistance*
- *Le côut d'hospitalisation au point du vue médical*

Canadian Hospital Association

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In the modern factory of The Canadian Laundry Machinery Co., quality is not merely strived for, but consistently attained in every machine produced. In every department, all efforts are continually directed toward making CANADIAN laundry equipment the finest possible. That is why each machine is quality-built for many years of dependable and superior performance.

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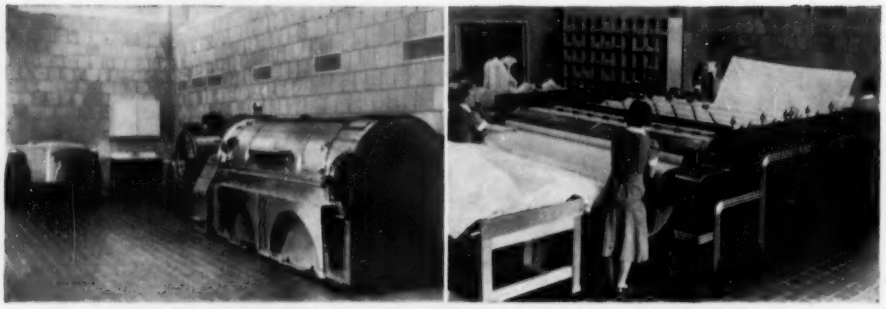
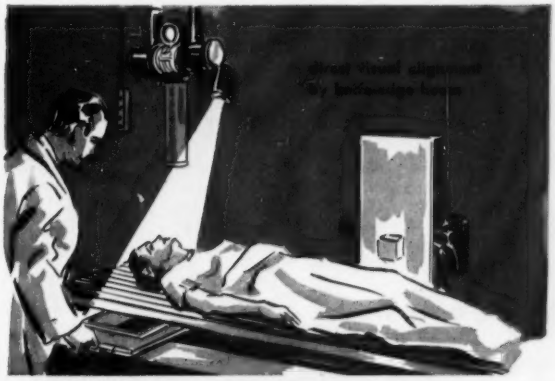
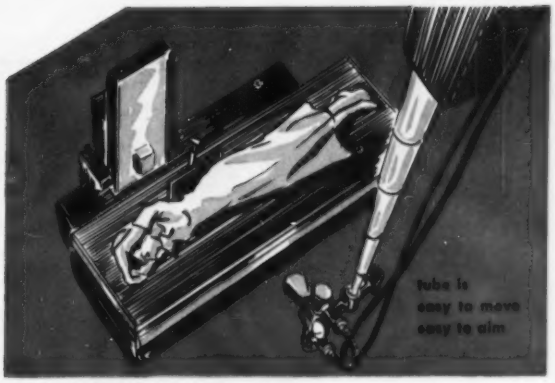


At New Aberhart Memorial Sanatorium, Edmonton, Alberta, laundry department was planned and completely equipped by CANADIAN. Shown at left, above, are CASCADE Automatic Unloading Washer with Full-Automatic Washing Control, CASCADE End-Loading Washer and NOTRUX Extractor. At right is 6-Roll SUPER-SYLON Flatwork Ironer.



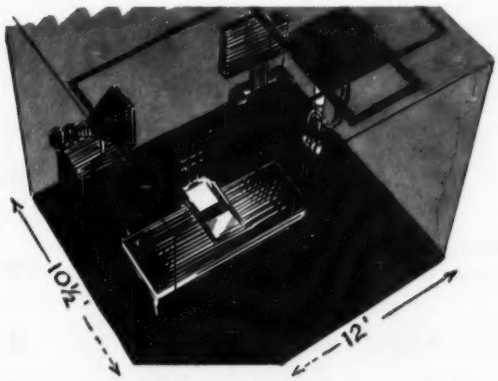
can you quickly center x-ray beam—to body part—to Bucky without having to match up separate scales for tube position and table position?



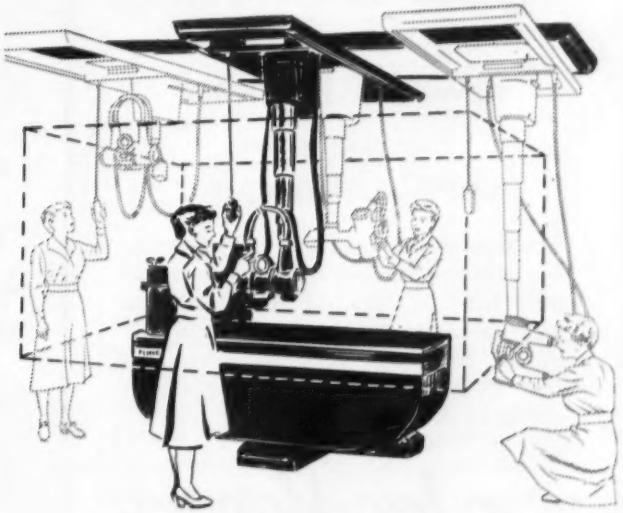
can you do lateral radiography from the front, or from either end, or from the rear of the table?

can you (or a group) stand or work *anywhere* around the full circuit of the table . . . front, back, head or foot?

can you radiograph a stretcher case in front, or at either end, or behind the table without hindrance . . . *and without having to shift the table?*



can you place pieces of auxiliary apparatus *anywhere* in the room with plenty of floor space to run a stretcher up to, and work easily at them?



can you do all this in a room only 10½' x 12'? (the girls spotted around the table show how easily you can position the x-ray tube anywhere within the dotted-lines)

you get through *more* work *faster*
and *more accurately* because

you can with the Picker x-ray Constellation **x-ray table**

and Ceiling Tubemount

PICKER X-RAY OF CANADA, LIMITED—1074 Laurier Ave. West, Montreal, P.Q.

Contents

Vol. 31 **October, 1954** No. 10

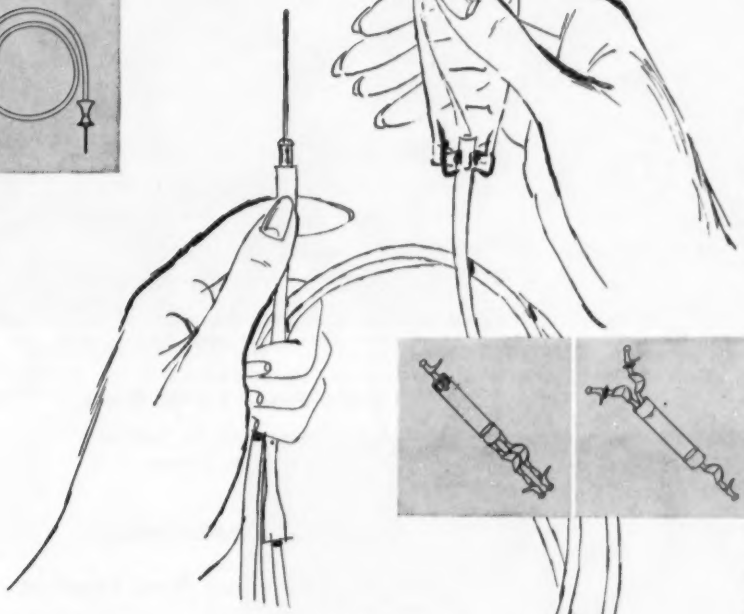
(For Subscription Rates, see page 126)

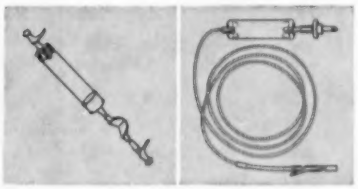
for
blood
collection

PLEXITRON

expendable sets

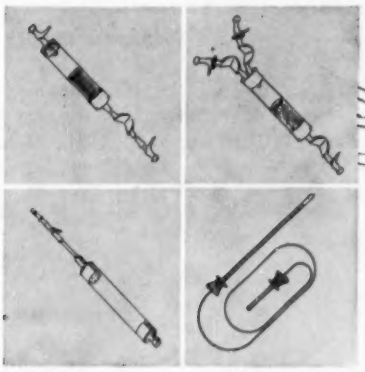
...the right set for every parenteral requirement





for solution
administration

for blood administration
and plasma aspiration



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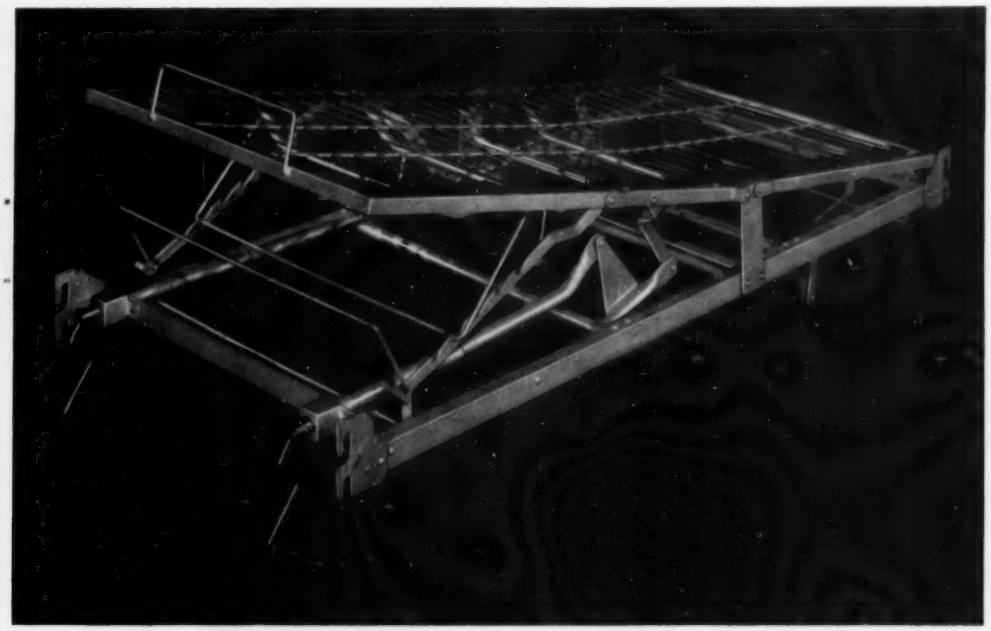

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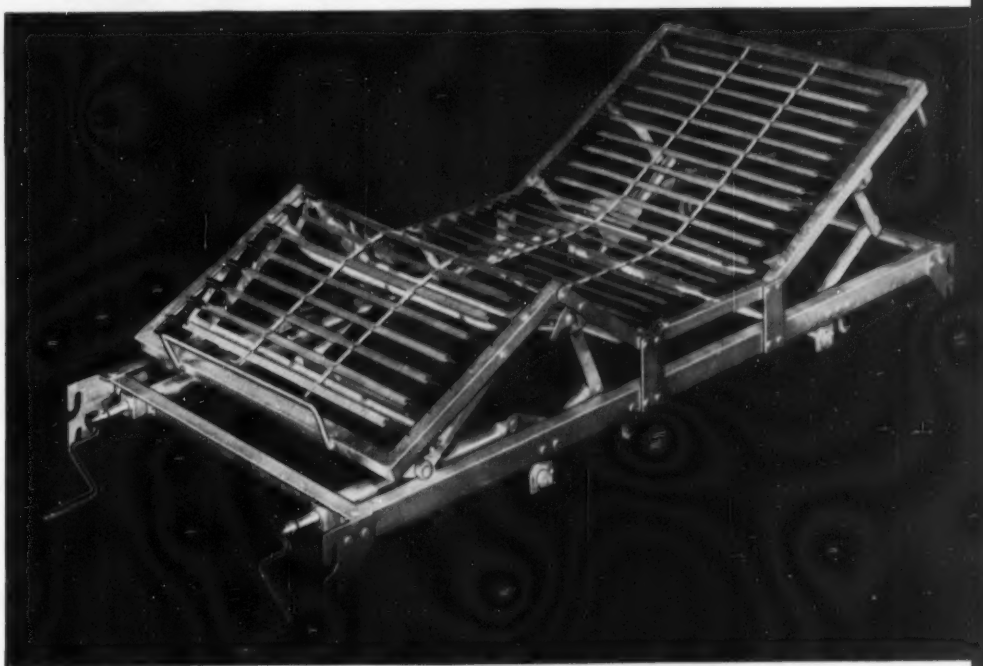
6061 "UNIVERSITY SPRING". Slat fabric. Two folding end cranks activate the double gatch frame for the positions of Trendelenburg—reverse Trendelenburg—Hyperextension and Fowler. Smooth in operation—sturdy in construction.



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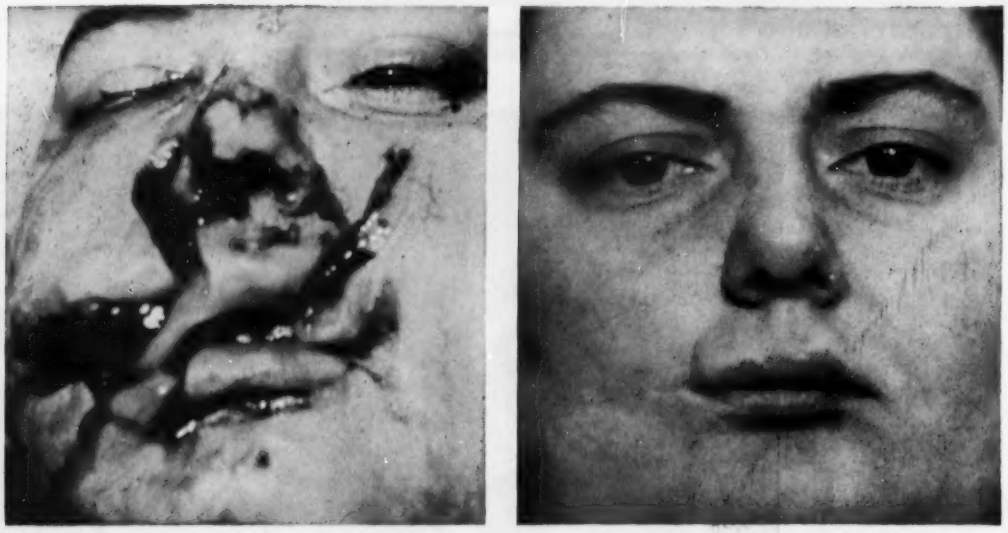
save faces, save futures with D & G needles and sutures

When your skill in surgery gives a patient a "new face" or restores his battered features, you are providing him with a passport to a brighter future. Often your proficient technic can minimize disfigurement from accidents, correct deformities in children and add to the earning years of older persons. "This year one million persons in this country will be injured in auto accidents alone. . . ."*

For minimal scarring, choose from a wide and varied line of D & G ATRAUMATIC® needles and sutures for plastic, skin, cleft palate and harelip work. D & G needles are extra-sharp, temper-tested, perfectly formed. They are available swaged on to ANACAP® braided silk, the silk with extra tensile strength; DERMALON® monofilament nylon, uniformly round and easy to withdraw; SURGICAL GUT, possessing greater flexibility and superior knot strength and SURGALOY® stainless steel, the metallic sutures of exceptional strength, flexibility and inertness.

*Straith, C. L., and Straith, R. E., Detroit, Michigan: Postgrad. Med. *14*:165, Sept., 1953.



Borders approximated accurately with figure 8 nylon sutures tied inside nose or mouth to relieve tension. Surface closed with fine braided white silk or nylon and 4-0 or 5-0 subcuticular suture. Note minimal scarring with good primary closure.

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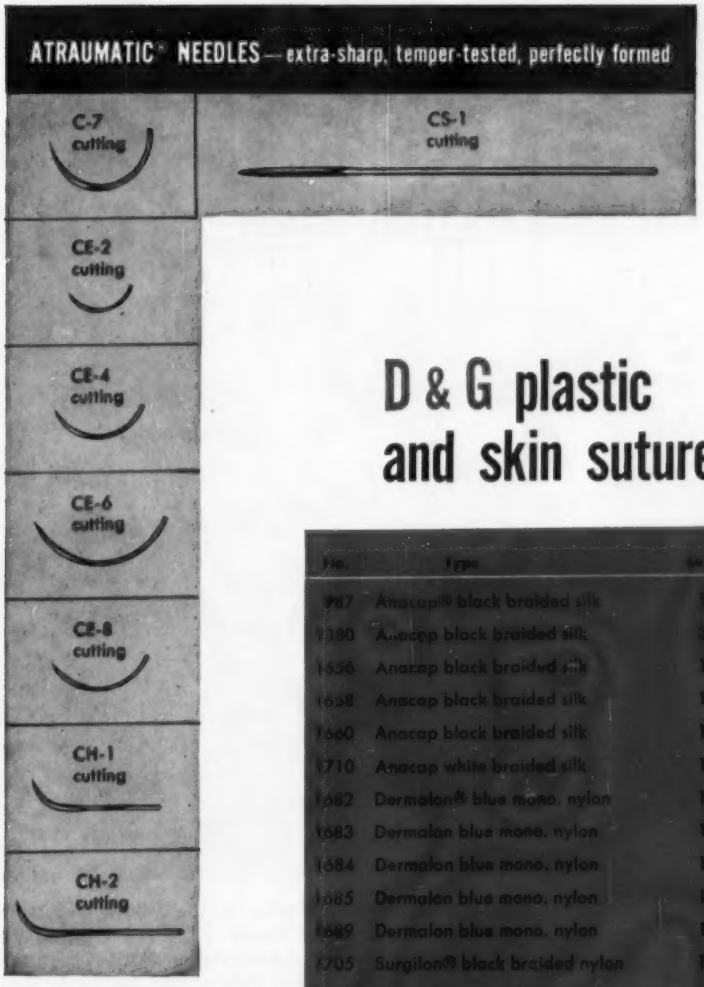

D & G plastic and skin sutures

No.	Type	Length	Needle	Sizes
987	Anacap® black braided silk	18"	CE-6	000, 00
1380	Anacap black braided silk	30"	CS-1	000 to 0
1656	Anacap black braided silk	18"	CH-2	000, 00
1658	Anacap black braided silk	18"	CH-1	4-0
1660	Anacap black braided silk	18"	CE-4	6-0 to 4
1710	Anacap white braided silk	18"	CE-2	6-0, 5-0
1682	Dermalon® blue mono. nylon	18"	CE-4	6-0 to 0
1683	Dermalon blue mono. nylon	18"	CE-6	4-0 to 0
1684	Dermalon blue mono. nylon	18"	CE-2	5-0, 4-0
1685	Dermalon blue mono. nylon	18"	CH-1	5-0, 4-0
1689	Dermalon blue mono. nylon	18"	CH-2	000, 00
1705	Surgilon® black braided nylon	18"	CE-4	4-0
1641	Surgical cotton, blue	18"	CE-4	000
1653	Silkworm gut, black	14"	CE-4	4-0
1803	Surgaloy® mono-str. stainless steel	20"	CE-4	6-0
1808	Surgaloy mono-str. stainless steel	20"	CE-6	4-0
1813	Surgaloy multi-str. stainless steel	20"	CE-4	5-0

D & G cleft palate and harelip sutures

No.	Type	Length	Needle	Sizes
1761	Surgical gut plain non-boilable	18"	CE-6	5-0
1763	Surgical gut mild chromic non-boilable	18"	CE-8	5-0
1682	Dermalon blue mono. nylon	18"	CE-4	6-0 to 0
1806	Surgaloy mono-str. stainless steel	20"	C-7	4-0

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From the Mount Royal Hotel to the Mount Stephen Club . . . from Martin's to "Ben's" . . . the leading hotels, clubs and restaurants shown above are just a sample of the famous eating places throughout Montreal that are equipped with Moffat Commercial Cooking Equipment. There are many reasons for this overwhelming preference.

(a) Moffat has equipment for every cooking requirement . . . from the simplest to the most complex . . . with flexibility, speed and efficiency.

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If you have a cooking equipment problem . . . large or small . . . we cordially invite you to consult with Moffat experts.

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2 JOHNSON'S WAX ways to lustrous floors at lower cost!

Last longer . . . buff brighter . . . give real wax protection!

Johnson's Paste Traffic Wax. Nothing else can give public floors the rugged, long-lasting *protection* . . . the mellow *shine* . . . of Johnson's Paste Traffic Wax.

Paste Traffic Wax is the genuine buffing wax made especially for practical service on large floor areas. It buffs quickly into an extra-tough, *wear-resisting* film. Seals pores of wood against stains, dirt and pounding traffic. Makes big floors simple and remarkably easy to clean. And you need just one pound of economical Traffic Wax for 400 sq. ft. of floor!

Johnson's Beautiflor Traffic Wax . . . cleans as it waxes! Never again need you scrub away the life of your wood and linoleum floors! Johnson's new Beautiflor Traffic Wax cleans and waxes these floors as manufacturers of flooring recommend they should be cleaned and waxed—without water, without soap, without harsh cleaners.

Beautiflor cuts cleaning and waxing costs as much as ⅓. It's tough wax combined with *extra cleaning power*—the only wax especially made for the "clean-as-you-wax" method of floor care. *And you don't get wax build-up!* Beautiflor dissolves the old film as it leaves a new coat of tough, protective wax which is then buffed to a glorious lustre.

Write today for free information and prices on Johnson's Paste Traffic Wax, Johnson's Beautiflor Traffic Wax and other cost-cutting Johnson's Wax floor care products.

S. C. Johnson & Son, Ltd.
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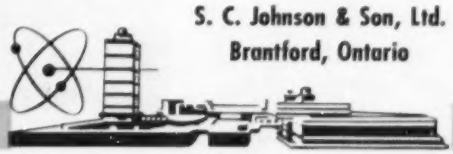

Notes About People

New Administrator Appointed at Ottawa Civic Hospital

Douglas R. Peart, formerly administrator of the General Hospital of Port Arthur, Ont., has been appointed superintendent of the Ottawa Civic Hospital, Ottawa, Ont. He succeeds Dr. W. Douglas Piercey, who is the new executive director of the Canadian Hospital Association.

Douglas R. Peart

Mr. Peart obtained his bachelor of commerce degree from Queen's University, Kingston, Ont., and during World War II supervised Canadian Army hospitals in England. At the end of the war, he was made chief of personnel for D.V.A. hospitals in Canada. Later, he was transferred to the Department of Fisheries, Ottawa. In 1949, he enrolled in the post-graduate course in hospital administration, at the University of Toronto. He served his administrative residency at the Toronto East General and Orthopaedic Hospital. In 1951, Mr. Peart was appointed to the Port Arthur hospital.

* * * *

Nursing Appointment at McKellar General Hospital

Grace E. Johnson, Reg. N., has been appointed director of nursing and director of nurse education at McKellar General Hospital, Fort William, Ont. She replaces Mrs. S. A. Crozier who has retired from an active nursing career.

Miss Johnson is a graduate of the school of nursing at the Winnipeg General Hospital, Winnipeg, Man., and obtained a bachelor of nursing degree (administration) from McGill University, Montreal, P.Q. She held the position of assistant director of nursing at the Winnipeg General and later was appointed director of nursing at the maternity pavilion there. She served in the Royal Canadian Army Medical Corps from 1940 until 1945, both in Canada and overseas.

* * * *

Norman A. Brady Receives Appointment in Chicago

Norman A. Brady, formerly of Toronto, has been appointed assistant director of the Presbyterian Hospital, Chicago, Ill. In 1951, Mr. Brady was appointed business manager of Sunnybrook Hospital (D.V.A.), Toronto, Ont., and held that position until 1953. In November, 1953, he became director of the methods and improvement program at St. Luke's Hospital, Chicago, a post he left to assume his new appointment. Mr. Brady is enrolled on a part-time basis in the Hospital Administration Program at Northwestern University, Chicago.

Norman A. Brady

Appointed Chief of Child and Maternal Health Division

Dr. Jean F. Webb, outstanding Canadian paediatrician and authority on maternal health, has been appointed chief of the Child and Maternal Health Division of the federal health department. Dr. Webb has been acting chief of the division since the resignation of Dr. Ernest Couture in 1952.

A native of Saint John, N.B., Dr. Webb is a graduate of Acadia, McGill, and Toronto universities and holds degrees in science and medicine as well as a diploma in public health. She also took extensive training in paediatrics at the Hospital for Sick Children, Toronto.

From 1945 until 1948, Dr. Webb was public health physician and director of nutrition services for New Brunswick's department of health and social services. In 1949, she joined the Harvard University School of Public Health, Boston, Mass., as an instructor and research fellow, and the child health division of the Boston Children's Hospital as a physician. Dr. Webb entered the Department of National Health and Welfare in 1951 as a paediatric consultant in the child and maternal health division.

* * * *

Congratulations to Sam Wynn

S. N. "Sam" Wynn of Yorkton, Sask., is well known to hospital people as a past-president of the Saskatchewan Hospital Association, and chairman of the board of the Yorkton General Hospital. He is well known to the newspaper field as owner and editor of *The Enterprise* and was recently honoured by his confrères when he was named "Mr. Editor of 1954" by the Canadian Weekly Newspaper Association. Congratulations to Mr. Wynn who, by the way, is also a good friend as well as a provincial correspondent of *The Canadian Hospital*.

* * * *

James Alcorn Brackenridge

James Alcorn Brackenridge, treasurer of the Royal Ottawa Sanatorium, Ottawa, Ont., died in August after a lengthy illness. Mr. Brackenridge had been a member of the Sanatorium's staff for 13 years. Born and educated in Belfast, Northern Ireland, he came to Canada 43 years ago.

(Continued on page 16)

Never before so efficient, so practical, so neat, so necessary

GABRIEL WILLIAMS' New

BED-MATE*

A BEDSIDE WASTE DISPOSAL UNIT

Fold on score mark to expose adhesive.

Starting from center of fold peel off top layers of brown protective coating.

Open bag, fold in flaps. Ready for use.

Attaches quickly, easily to bedside, between mattress and spring, or adheres directly to linen. No more safety pin tears. No wasteful use of costly adhesive tape. No expensive, bulky wire frame.

Practical and efficiency-promoting used along side table.

Affixes instantly to wall to provide neat and attractive extra waste disposal receptacle.

Designed on an entirely new principle, Bed-Mate functions beautifully on bed, table or wall. With Bed-Mate, no more costly bulky wire frame holders, no more unsightly brown paper bags, no more safety pin tear damage to sheets, no more wasteful use of adhesive tape.

Bed-Mate features the strongest adhesive yet developed for this type of usage. Adheres instantly and effectively to metal, wood, glass, formica, linen, and all other dry surfaces. Peels off easily, quickly, without marring surface or leaving any marks or stains.

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Profit by these October

FROM THE KRAFT KITCHENS...

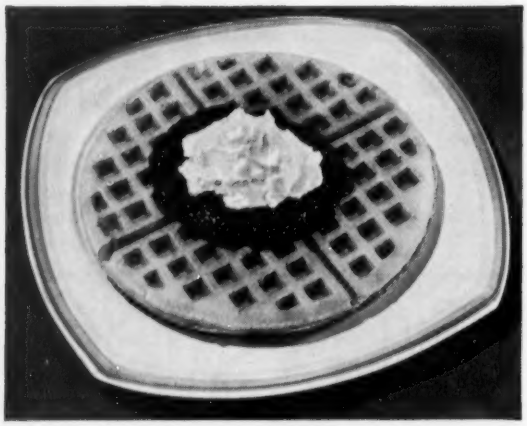
The accent's on *cheese* in October . . . Cheese Festival month! Cheese Festival puts many fascinating varieties of cheese in the spotlight, urging more people to eat more cheese in sandwiches, casseroles, omelets and salads. Tie in with this year's biggest cheese promotion . . . feature these tasty cheese menu items for breakfast, lunch and dinner during October, 1954.

Breakfast

Cheez Whiz Omelet

Here's the easy, profitable way to make a cheese omelet. All you have to do is spread golden-rich Kraft's Cheez Whiz over your favorite omelet —fold and serve.

Kraft's Cheez Whiz packed in 1-lb. jars.



Waffles with Cream Cheese and Jam

Here's a breakfast dish that's tremendously popular! Bake waffles—in the center of each hot waffle place a generous amount of jam, then top with Kraft Cream Cheese which has been softened at room temperature and whipped with a little milk until light and fluffy.
Delicious and satisfying!

Kraft Cream Cheese available in 3-lb. loaves.

CANADIAN CHEDDAR CHEESE AND IMPORTED VARIETIES • PASTEURIZED PROCESS CHEESES • CREAM CHEESES • GRATED CHEESES • KRAFT MAYONNAISE • MIRACLE WHIP SALAD DRESSING • CUISINE SALAD DRESSING • KRAFT FRENCH AND MIRACLE FRENCH DRESSINGS • PREPARED MUSTARD AND MUSTARD WITH HORSERADISH ADDED • PARKAY MARGARINE

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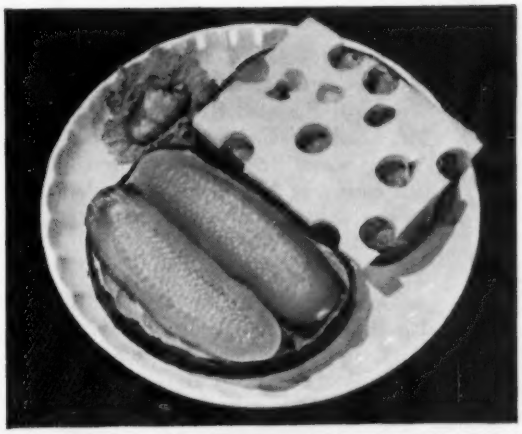
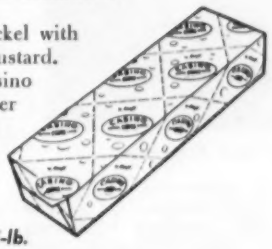
Cheese Festival Treats



Lunch

Swiss Cheese and Dill Pickle Sandwich

Spread 2 slices of pumpernickel with Kraft Prepared Salad Style Mustard. Top one with a slice of Casino Brand Swiss Cheese and the other with 2 lengthwise slices of dill pickle. Serve open style with a spoonful of mustard in a lettuce cup.



Casino Brand Swiss Cheese—in 5-lb. and 10-lb. blocks—no rind, no waste.

Welsh Rabbit

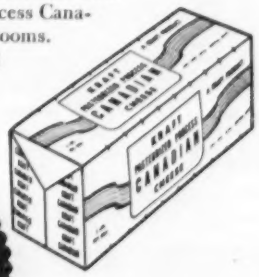
For a grand, sharp-tasting Welsh Rabbit melt Kraft Sharp Cheddar Cheese. Add liquid as desired. Pour the cheese sauce over toast triangles and sprinkle with toasted sliced almonds. Serve with tomato wedges garnished with parsley.

Kraft Sharp Cheddar Cheese available in 5-lb. and 10-lb. rindless blocks.

Dinner

Macaroni and Cheese Casserole

To hot cooked well-drained macaroni add shredded Kraft Pasteurized Process Canadian Cheese and sautéed mushrooms. Toss lightly. Serve in individual hot casseroles.



Kraft Pasteurized Process Canadian Cheese available in 5-lb. loaf.

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DISTRIBUTED DIRECT AND THROUGH SERVICE-MINDED JOBBERS EVERYWHERE

Notes About People

(Continued from page 12)

Dr. Paul Bourgeois

Correction: In announcing the appointment of Dr. Paul Bourgeois as director general of Hôpital Notre-Dame in Montreal (*The Canadian Hospital*, September, page 12), we regret that an error occurred in that the name of the medical director, Dr. J. R. Boutin appeared under the picture of Dr. Bourgeois. Our apologies are extended to both gentlemen. A picture of Dr. Boutin who has recently been advanced to fellowship in the A.C.H.A. appears on page 26 of this issue.—*Edit.*

John Kunetsky Appointed to Sioux Lookout General Hospital

John Kunetsky was appointed administrator at Sioux Lookout General Hospital, Sioux Lookout, Ont., last August. Mr. Kunetsky, a former school teacher, began his hospital career with the Canora Union Hospital, Canora, Sask., as an accountant. From there, he went to the Stettler Municipal Hospital, Stettler, Alta., as secretary-treasurer, a position he held until his present appointment. Mr. Kunetsky completed the Canadian Hospital Association extension course in hospital organization and management, this year.

* * * *

New Appointment at Welland

Jackson Ross Bryan has been appointed superintendent of the Welland County General Hospital, Welland, Ont., and assumed his new duties on September 1st. Mr. Bryan is a native of Port Arthur, Ont. He attended the Royal Military College in Kingston, Ont., later being graduated with a bachelor of arts degree from the University of Toronto. Mr. Bryan also holds a master's degree in psychology. He received administrative training while serving with the Royal Canadian Air Force, during World War II, and resigned the post of personnel director of an industrial firm in Welland to take over his new position. Mr. Bryan succeeds Harry Barnett, who resigned recently.

• Earl J. Goodwin has been appointed secretary-treasurer of the High River Municipal Hospital, High River, Alta. Mr. Goodwin succeeds the late Frank Swain, whose death in July, brought to a close over 20 years of outstanding service as secretary-treasurer of the hospital.

• George Bugbee, president of the Health Information Foundation, New York, N.Y., was chosen as the 1954 recipient of the American Hospital Association's highest honour, the Award of Merit. Mr. Bugbee was executive director of the A.H.A. from 1943 until May 1st, 1954, when he assumed the presidency of HIF.

(Concluded on page 20)

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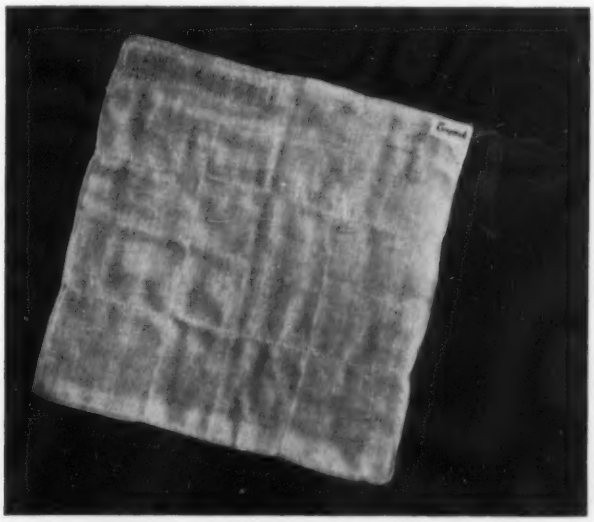

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Notes About People

(Concluded from page 16)

• Dr. R. F. Ohlke, assistant anaesthetist at the Royal Victoria Hospital, Montreal, for the past three years, has resigned to become chief anaesthetist at the Westminster Hospital, London, Ontario.

• Peter D. Ward, M.D., became a member of the staff of the American Hospital Association Council on Professional Practice on Sept. 1st. Dr. Ward, a native of Canada, is a former medical superintendent of the Montreal General Hospital, Montreal, P.Q.

• O.W. Titus has been elected chairman of the board of governors of the Toronto East General and Orthopaedic Hospital, Toronto, Ontario.

• Rev. Father Henri Légaré, O.M.I., executive director of the Catholic Hospital Association of Canada, has been appointed director of the School of Social, Economic and Political Sciences, University of Ottawa.

• James Frederick Maxwell, Ottawa, has been appointed chief of the personnel division of the Department of National Health and Welfare. Mr. Maxwell was formerly personnel officer for the Air Service Branch, Department of Transport, Ottawa.

• Dr. Hugh MacKay, a resident of New Glasgow, N.S., has been appointed medical supervisor of the new Aberdeen Hospital, New Glasgow. During World War II, Dr. MacKay administered various military hospitals and served on a hospital ship in charge of the medical section.

Hospital Safety Contest To Be Sponsored by A.H.A.

A hospital safety contest will be conducted during 1955 by the American Hospital Association, in co-operation with the National Safety Council. The Association's committee on safety of the Council on Hospital Planning and Plant Operation proposed this nation-wide contest to stimulate added interest in safety.

Any member hospital of the Association will be eligible to enrol in the contest which will run from January 1st to December 31st. Entrants will be classified into eight categories according to the number of full-time employees. The hospital in each group which has the lowest injury frequency rate, during the entire contest, will receive first place awards. All hospitals which complete the year without a reportable injury will receive perfect record awards. The grand award will go to the hospital which shows a perfect safety record with the greatest number of man-hours of work during the contest.

Statistics on Mental Illness

At the present time in Canada, over 62,000 mental patients are hospitalized. This means that 4 out of every 1,000 persons in Canada are suffering from a serious mental illness. This means that every home, every factory, every community is touched directly or indirectly by the pain and anguish of the mentally ill. — *Reva Gerstein, Ph.D.*


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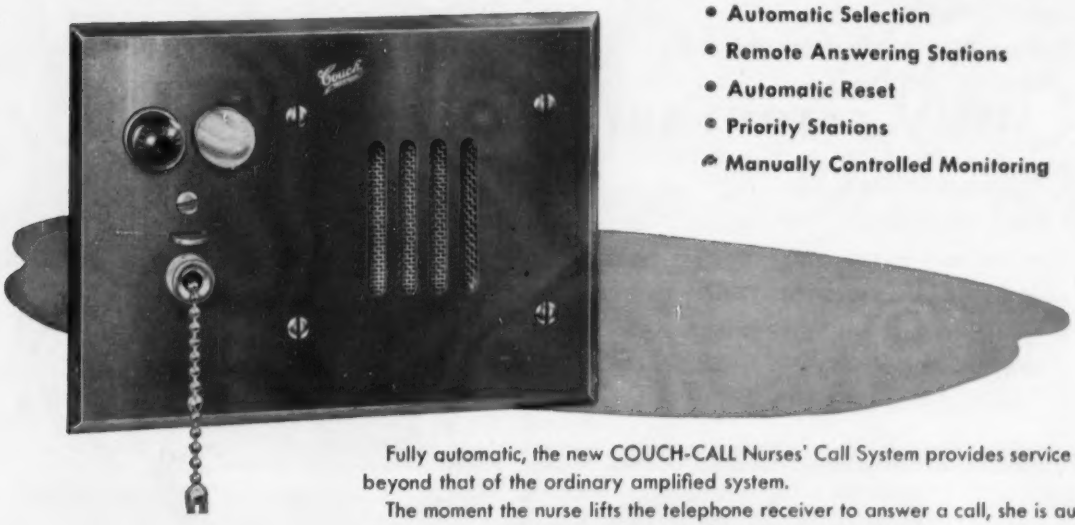

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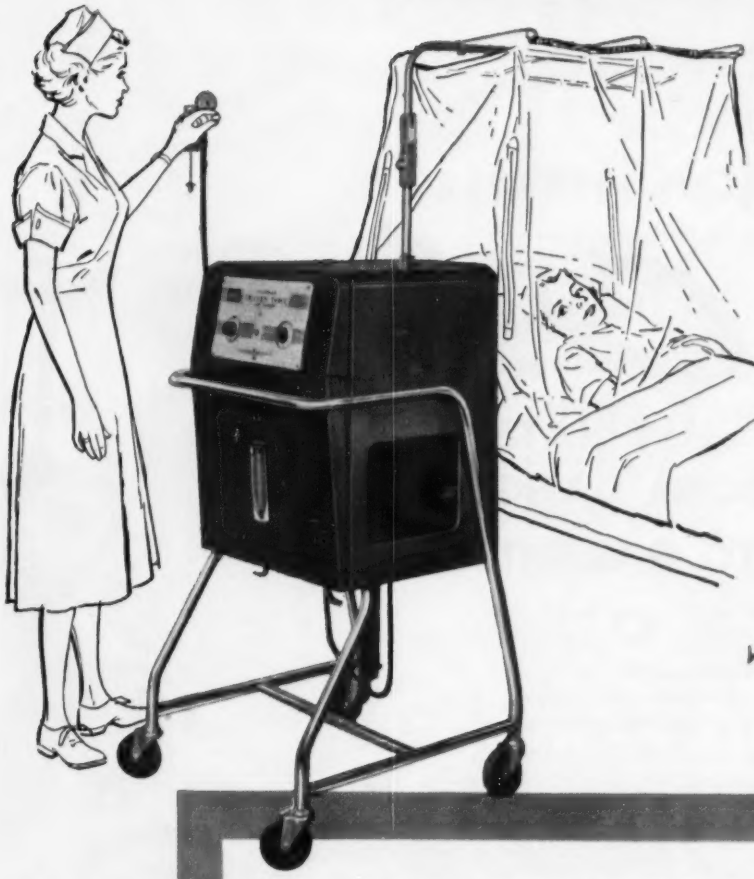

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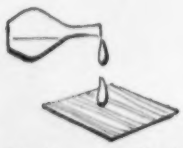

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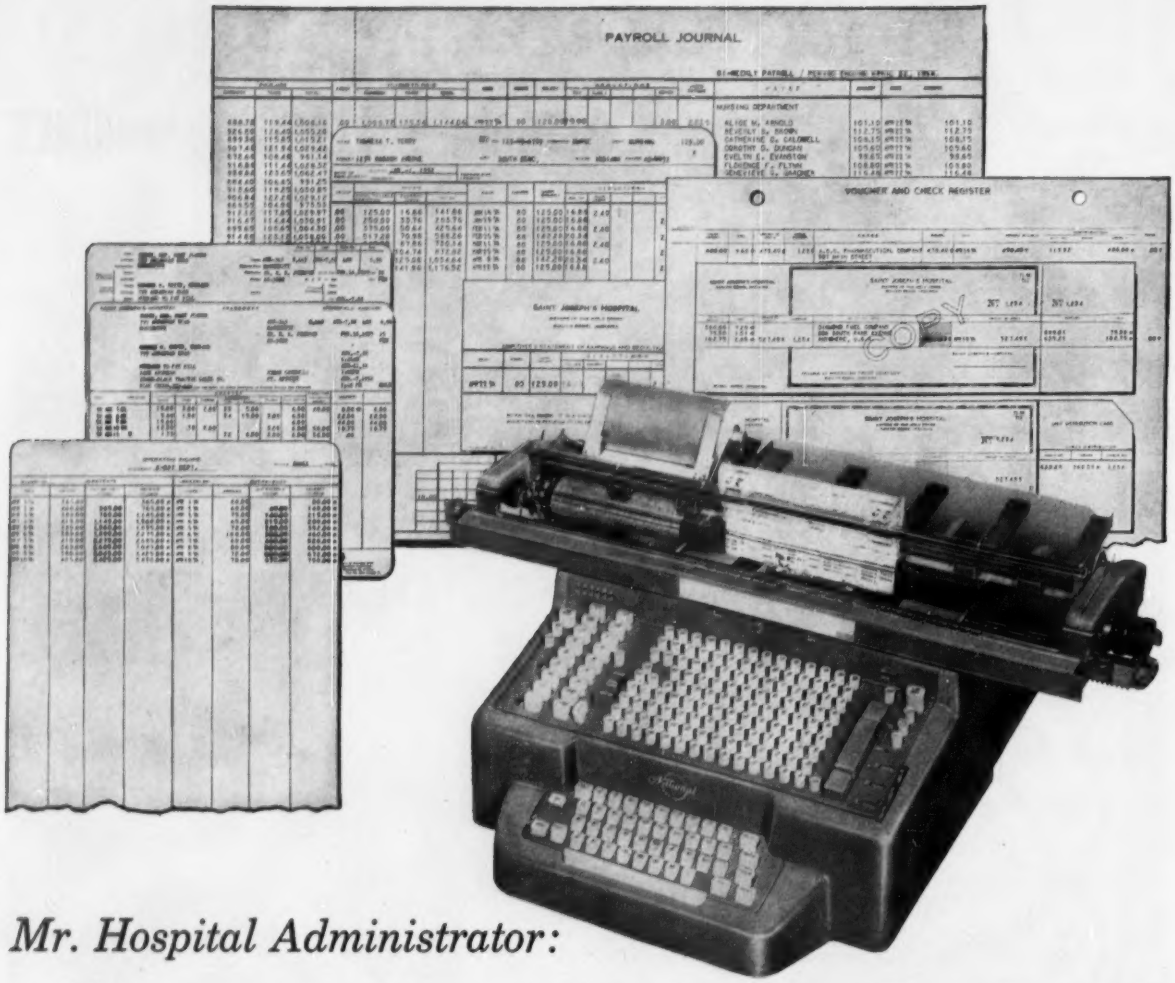

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A. L. Swanson, M.D. Editor

The Canadian Hospital

Obiter Dicta

Au Revoir

AN EDITOR'S tenure of office spans several epochs which are reminiscent of the human life cycle. Birth, maturity, marriage, the climacteric and death may mark the passage through time of editors as well as humans. Certainly one's first few editorials resemble the preliminary struggle of the infant. Everything appears new and unexplored. The editorial pathways to follow are legion; the thoughts that await expression are many. Yet the ability to choose the right editorial path and to express thoughts on paper is undeveloped.

However, when the first faltering steps are mastered there comes a measure of maturity that grows with time and practice and leads eventually to adulthood. So the editor, as he develops self-assurance and pride in his publication, may eventually become almost wedded to his journal. As real home life has its ups and downs so has an editorship. The publication is a source of joy and pride—it is also a responsibility and a tie. There is pleasure to be found in producing a good issue, in making improvements in its format, in the financial success of the publication. There is the challenge of securing good scientific articles, of meeting deadlines every month of every year, of satisfying the readers.

Our editorial home has had many blessings. An editor's joy at seeing the first article by a new and able writer is akin to the family pride in an offsprings's initial success in some new venture. The contributions of faithful authors might be likened to the security offered by a fire on the hearth and a well-filled cupboard. Moreover, the loyal editorial and advertising staff, with their many skills, have more than done their share to accentuate the pleasant aspects of our journalistic life.

To Doctor Piercey we commend the *Canadian Hospital* family of readers, authors, and staff. We cannot imagine a warmer, more helpful group for him to join. Neither could we hope for a finer man to take our place.

Dr. Piercey, as superintendent of the Ottawa Civic Hospital, has long been looked upon as one of the leading administrators in Canada. As past-president of the Ontario Hospital Association and as a director and 2nd vice-president of the Canadian Hospital Association, he has gained wide experience in association work. To quote Dr. Harvey Agnew, "Dr. Piercey is a clear thinker, very practical, an excellent presiding officer, a good lecturer and a man who commands the respect of all who know him."

One's last editorial, like the first, is difficult in the extreme. However, the knowledge that the journal is passing into such competent hands eases the task of relinquishing the post. To Dr. Piercey and all the editorial family we should like to convey our best wishes, our thanks and the assurance of our continuing interest and support.—*A.L.S.*

Au Revoir

LA PERIODE d'administration d'un éditeur traverse plusieurs époques qui rappellent les étapes de la vie humaine. Naissance, maturité, mariage, épanouissement, mort, peuvent marquer le passage des éditeurs—comme des humains—à travers le temps. En effet, les premiers efforts éditoriaux ressemblent aux premières luttes du bébé. Tout paraît neuf et inexploré. Les routes à prendre sont nombreuses—plusieurs idées se présentent à l'esprit et cherchent expression. Cependant, il manque encore la capacité de choisir sûrement la bonne route éditoriale, et de s'exprimer clairement par écrit.

Toutefois, après qu'on a maîtrisé les premiers pas timides, on grandit peu à peu, on se rassure avec le temps et l'application, et enfin on se

trouve adulte. Ainsi, l'éditeur, à mesure qu'il gagne de l'aplomb et devient fier de sa publication, peut se trouver enfin, comme l'épousé de son journal. Comme la vie domestique a ses beaux et ses mauvais jours, ainsi coule la vie éditoriale. Le journal devient une source de fierté et de joie—il devient aussi une responsabilité et un lien. On se plaît à présenter un numéro intéressant, à améliorer son format, à le voir réussir financièrement. On a intérêt à obtenir de bons articles scientifiques, à présenter le journal à temps, à chaque mois de chaque année, à satisfaire les lecteurs.

Notre foyer éditorial nous a fourni beaucoup de bonheur. La joie que ressent un éditeur en lisant le premier article d'un nouveau contributeur est semblable au bonheur que ressent la famille d'un enfant qui rencontre son premier succès. Les contributions d'auteurs fidèles créent un sentiment de bien-être et de sécurité, tout comme celui que donnent un bon feu et une table bien garnie. En plus, le personnel éditorial et le personnel des annonces ont largement contribué, par leur loyauté et leurs talents, aux joies de notre vie journalistique.

Au Docteur Piercey, nous recommandons les lecteurs du *Canadian Hospital*, ses contributeurs et son personnel. Il ne pourrait se joindre à un groupe plus amical ou plus habile. Non plus, nous ne pourrions demander pour un plus compétent successeur.

Le Docteur Piercey, comme surintendant de l'Hôpital Civic d'Ottawa, a depuis longtemps été considéré comme l'un des administrateurs les plus en vue au Canada. Dans le passé, comme président de l'Association des Hôpitaux de l'Ontario, et aujourd'hui comme directeur et deuxième vice-président de l'Association des Hôpitaux du Canada, il a acquis une vaste expérience du travail de l'Association. Le Docteur Harvey Agnew a dit de lui: "Le Docteur Piercey est un penseur logique et pratique, un excellent officier-président, un bon conférencier et un homme qui commande le respect de tout ceux qui le connaissent".

Le dernier article éditorial, comme le premier, est des plus difficile à écrire. Toutefois, je quitte ce poste avec moins de regret, puisque j'ai l'assurance que le journal est entre bonnes mains. Au Docteur Piercey et à toute la famille éditoriale, j'envois mes meilleurs voeux, mes sincères remerciements et l'assurance de mon intérêt et de mon soutien continus.—*A.L.S.*

Are you interested in donations for your hospital?

SUCH A QUESTION must be almost rhetorical when directed to administrators and trustees. Although some provinces operate a hospital insurance that covers hospital needs to a greater or lesser degree, even in those areas donations are very welcome. Certainly, most public hospitals can use gifts to advantage and, in many areas, public appeals are made regularly.

Whether at the time of a special fund-raising drive or during another part of the year, the approach to a prospective donor may be difficult. One way to make the initial contact easier is to remind the individual or industry that donations to public hospitals are tax-exempt. A gift to the hospital costs only a fraction of its face value in that, for every dollar given, a portion represents a tax exemption that would otherwise be paid out as a part of the tax return for the year.

To assist hospitals in obtaining donations, the Canadian Hospital Association has recently printed a small brochure entitled *Tax Savings Through Donations to Hospitals* — see page 118 of this issue. It is designed for mass circulation, during fund-raising appeals or at any other time, to potential donors such as well-to-do patients, relatives, philanthropic organizations, and so on. It may be utilized by women's auxiliaries, medical staffs, hospital societies, or other groups interested in securing financial support for the hospital. The brochure is eye-catching in appearance, concisely written, and is available in French as well as in English.

Samples of this latest publication of the Canadian Hospital Association have already been sent to public hospitals and hospital organizations because we believe that this booklet will assist hospital people in their approach to donors and will encourage philanthropy towards hospitals in this country.

Visiting Hours—more leniency please

DURING the past few years, hospital literature has been plentiful on the subject of visiting hours in hospitals. Some writers present the case for carefully controlled visiting. Others are in favour of a relatively liberal policy, allowing visitors to come at almost any time during the day and evening.

Undoubtedly both systems have their advantages and disadvantages. The system that works best for any one hospital may be entirely unsuitable for another, while a compromise between the extremes of strict control and relative freedom may be the answer for many hospitals. Whatever the case, the writer has long felt that visiting regulations are often needlessly strict. This opinion has been strengthened over the years by the comments of many friends and colleagues both in and out of the hospital field. Furthermore, from his own observations and experience in several hospitals during recent months, the writer has been convinced of the desirability of a reasonably lenient visiting policy.

Where visiting hours extend throughout most of the day and evening, visitors almost seem to disappear. Gone are the crowds in lobbies awaiting a deadline. Ward corridors are quiet, with scarcely a visitor to be encountered. Indeed one can enter the hospital many times without so much as seeing another visitor. Personally, the thought that one can return almost at will induces a sense of security. When there is no fear of being denied access to a loved one, the visitor is encouraged to leave early, secure in the knowledge that tomorrow morning is not far away. Quite likely tomorrow morning will come and go without any need to visit.

Naturally there must be some regulation of visitors. Problems which require delineation and a restrictive policy may well arise in connection with small children, the very ill, certain areas in the hospital, and the occasional noisy visitor. However, many hospitals on this continent have achieved better public relations, improved patient morale, and enthusiastic support from staff, by modifying visitor controls. The writer would submit that if other hospitals would review their policies, less rigidity in visiting regulations would be found desirable in many situations.

Labour Problems in Hospital Administration

Sr. M. Berthe Dorais, F.A.C.H.A.
Administrator,
St. Boniface Hospital,
St. Boniface, Man.

THE TOPIC "Labour Problems in Hospital Administration" suggests, and rightly so, that there are particular labour problems in hospitals. Industrial leaders know that the higher the percentage of production dependent on the efforts of people, as contrasted to machines, the more difficult management becomes. The prevention and cure of all kinds of physical and mental ills and the development and training of professional and non-professional people constitute what may be called the *product* of hospitals. This product is almost 100 per cent dependent on personal effort. True, machines may be used in hospitals to the extent that they are used in hotels for purposes such as dish-washing, floor-washing, wall-washing, et cetera. Here, as in hotels, these machines become labour-saving devices designed to increase the volume of work without increasing cost. But when machines are used for treating patients or for preparing medical and surgical equipment which will, in turn, be used for treating patients, the demand on personal effort becomes much greater; because the machine is then used, as a rule, by one specially-trained individual to perform one procedure for one patient. No method of bulk testing can be used here. It follows, therefore, that management function respecting personnel in hospitals is a most difficult one.

Hospitals, dealing with life and death and operating 24 hours a day are very different from industry. When Norman D. Bailey, who had been trained in industrial personnel relations, was appointed personnel director of a large hospital in Chicago in 1946, he immediately recognized that the transition from the field of industrial personnel to that of institutional personnel involved certain changes in approach to the problems of the personnel office.

He wrote: "From the industrial field come certain basic personnel concepts, among these: efficiency of operation, importance of useable records, need for training and indoctrination programs even for non-skilled groups, and motivation of production through incentives". Yet the following questions arose in his mind:

"1. Are the personnel records adequate to give a ready picture of each employee? If not, what records would be desirable in the institutional personnel office?

"2. What procedures are followed for indoctrination and training of non-professional employees? Are these procedures perfunctory or are they organized with the view of instilling not only work regulations but also service ideals?

"3. Turnover at semi-skilled and unskilled levels in hospitals, as in industry, has been far in excess of the figure necessary for efficient operation. What are the underlying causes of this turnover? What is the turnover costing in service rendered, in financial outlay, in public attitudes, in hospital morale?

"4. Along with turnover goes the whole problem of absenteeism. What factors enter this picture? Are there any that could be eliminated by more careful pre-employment screening? Is it possible to provide other remedial measures?

"5. Are job specifications available in sufficient detail to make pre-employment screening and interviewing effective in reducing job dissatisfaction?

"6. Is there any program of pre-employment aptitude testing that is applicable to employment procedures at non-professional levels? What are the bases for decision on the aptitudes of prospective employees? Industry knows, for example, that there are ranges in intelligence which set upper and lower limits for job happiness and job success. Can ranges be determined for certain tasks at non-professional levels in hospitals? What other test criteria can be applied?

"7. Does the wage incentive program apply in any way to the non-professional hospital employee? At first glance it would seem that there is *no* place for an incentive program in any employment directly affecting patients. Since the basic principle of the incentive is to provide increased remuneration through increased production at no increase in unit cost, one may well ask whether there is a place for the program and resulting job satisfaction. Is there some other motivation that would attain desired ends equally well or more advantageously in hospitals?

"8. In the past few years industrial personnel has become increasingly conscious of and attentive to services which can be classed under the general heading of 'employee welfare'. To what extent can institutional personnel programs meet these needs?

"Out of these questions will arise many more. Some will be answered. Many will call for research and thorough study over a considerable

Sister M. Berthe Dorais

This article is an adaptation of a lecture delivered to the St. Boniface Institute of Labour, St. Boniface, Man., April, 1954.

period of time."*

This research approach to the problem was again advocated by the American Hospital Association in a pilot study published in 1948. While the study indicated that in hospital personnel administration supervision created the primary problem, it became equally apparent that it would be impossible to base training programs for hospital supervisors on information and studies gained from industry. An urgent need was felt for further exploration of the human relationships and characteristics of the hospital organization. Authorative information to be used, if basic human relations problems were to be solved, was needed under the following heading:

Comparison of hospital organization with industry. The tensions and strains reportedly operating on hospital employees appeared in great degree to be different from those operating on industrial employees. It was felt that there could be no accuracy of analysis of the problems of hospitals without a comparison with the problems of industry to establish points of similarity and difference.

Functions of hospitals. The literature about hospitals is replete with materials testifying to their high purpose. We should study their actual functions —the needs they fulfill for the communities in which they operate and for the various levels of personnel who work in them. People come to hospitals because they are sick and injured, not because they choose to come to a hospital. The rich and the poor, the young and the old, all at one time or another are in need of hospital care. It is a service that must be made available to all, a service that must be motivated by a sincere solicitude for one's neighbour and animated by the love of God. As for the various levels of personnel who work in them, let us ask but one question, what of doctors and nurses without hospitals in the twentieth century?

The role of the doctor. The role of the doctor in a hospital is an aspect of hospital organization not at all similar to anything found in industrial studies. One can readily surmise how difficult, and at times impossible, is the adherence to work schedules in hospitals. This very point brings into play the whole problem of overtime in hospitals with its various interpretations as to the equitable methods of compensation. The patient cannot be subjected to regimentation because of the very nature of the services he requires, hence flexibility in time tables becomes essential.

Study of actual organization of people within the hospital. The attempt to chart actual operating relationships of authority and responsibility is still in the stage of infancy because of the difficulties involved. For instance, the executive dietitian is responsible to the administrator, yet the doctor orders diets, the director of nurses plans the education of student nurses for whose dietetics expericence the dietitian is responsible, the personnel director develops personnel policies to which the dietitian again is subjected. Hence, it is understandable that employees may at times receive orders from what appears on the surface to be two different sources of authority. Here the difficulty is more apparent than real.

Internal organization of basic subdivisions in total hospital structure. These basic subdivisions can be listed as follows: governing board, administration, medical staff, nursing staff, technical staff and non-professional staff. The internal organization of each of these subdivisions and the relationships of each to the others offer a large field of research.

Enough has been said to prove beyond a doubt that one must approach hospital labour problems with caution, an open-mind and above all with courage.

Have hospitals accomplished anything by way of improving their personnel relations program? We know that the cost of personnel has risen from 39 per cent of the total hospital budget of a few years ago to an incredible 66 per cent and even higher of total cost of operating hospitals as of today. Is this indicative of achievement and if so, to what extent? Has the increase in cost of personnel been paralleled by an increase in efficiency as well as job satisfaction? We further know that should the trend to increase personnel costs in hospitals continue, we will be subject to severe criticism from other organizations who have maintained a more realistic balance between personnel cost and cost of materials. I humbly submit that hospitals would not face the risk of losing public confidence because of tremendously increased hospital costs if everywhere the call for research had been heard. We must not make the mistake of moving along the line of least resistance which is to raise room rents and other charges to patients in order to balance the budget instead of settling down to a carefully-laid-out, in-service training that would result in improved service by injecting greater efficiency into the internal operational program of the hospital.

I believe that we have not sufficiently realized that while industry and hospitals may have similar aims in their personnel relations programs, at a certain point they differ radically; and this because the primary objective of industry and hospitalization is different. The former is concerned with money-producing units, the latter with human lives. The former controls its production according to demand, the latter renders services according to a need which defies all criteria of evaluation or regulation. In one word, the objective of industry is profit, the objective of hospitalization is good patient care. And because these objectives are so different, the means of achieving them are also different.

At this point let us list some comparisons between industry and hospitals.

1. *Industry* may or may not base its operations on a 40-, a 44- or a 48-hour week.

Hospitals must operate 168 hours a week.

2. *Industry* operates for profit, hence the manufacturing of any product selling at a loss is discontinued without delay.

Hospitals provide necessary services and must maintain every department whether or not there occurs financial losses in any one of them.

3. *Industry* reduces its staff as production diminishes.

Hospitals must maintain a certain level of staff always prepared to meet emergencies. Their personnel cannot be reduced in proportion to their day-to-day occupancy.

4. *Industry* measures the efficiency of its employees by standards of weight, measure, time, quantity and quality.

Hospitals are restricted in measuring the efficiency of employees to one standard only, namely, quality of patient care.

(Concluded on page 94)

Norman D Bailey "Industry and Hospitals Have Similar Aims in Their Personnel Relations Programs", "Modern Hospital", April, 1946, p. 80.

Au point du vue médical

Le Coût d'Hospitalisation

Eugéne Thibault, M.D.,
Directeur Médical,
Hôpital Général de Verdun,
Verdun, Quebec.

CE QUE les hôpitaux ont fait et font encore pour diminuer le coût d'hospitalisation, au point de vue médical: voilà le sujet que je dois développer. En commençant mon exposé, permettez que je rappelle deux vérités que nous ne devrons pas perdre de vues. D'abord, les médecins doivent faire les analyses et les expertises qui s'imposent lorsqu'ils croient être en présence de telle ou telle maladie, ou lorsqu'ils veulent poser un diagnostic. Nous verrons plus loin le rôle que jouent les différents comités dans ce domaine, et leur insistance auprès des médecins pour qu'ils examinent davantage leurs malades a pour résultat que seules les recherches nécessaires sont faites. Il ne faut pas cependant appliquer les freins trop fort, dans le but de ne pas grever la note du malade, car je suis d'opinion qu'une restriction inopportune viderait plus rapidement nos hôpitaux que ne sauraient le faire des notes élevées, et les services que nous rendrions ainsi aux malades ne seraient pas de premier ordre. Par contre les médecins ne doivent pas tomber dans l'excès contraire. Le bon Samaritain de l'Evangile n'a pas dit au charitable dispensateur de soins "gave le blessé, et fais-lui un traitement extraordinaire". Il a dit tout simplement, "panse-le, guéris-le et je te paierai à mon retour".

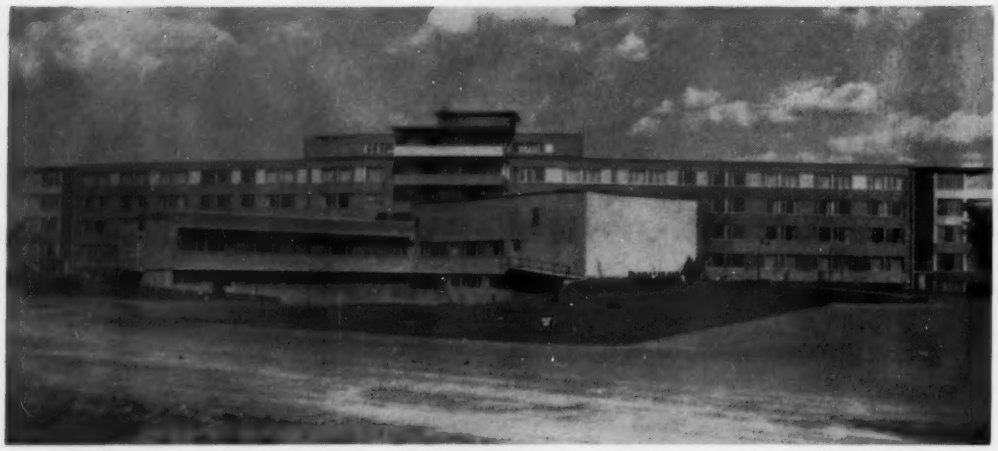
Secondement, l'art de prescrire et le traitement des malades appartiennent au médecin — il a toutes les responsabilités de cet acte. S'il commet des fautes, il doit les réparer et s'amender. S'il n'y voit pas lui-même, le corps médical prend l'affaire en main, d'où les conseils de discipline, les sanctions. Et c'est ainsi que nous avons vu le médecin perfectionner son art et s'imposer une discipline sévère. Je ne crois blesser personne en avançant qu'il y a 30 ou 40 ans, et peut-être n'est-il pas besion de remonter si loin, une bonne partie de la population était d'avis, à tort ou à raison, qu'il se faitait beaucoup trop d'opérations. On parlait de chirurgie simulée, chirurgie inutile, chirurgie illégale, plaies infectées qui n'en finissaient plus, formation scientifique insuffisante des chirurgiens, partage des honoraires, et que sais-je encore, jusqu'au jour où la profession médicale elle-même, après un sérieux examen de conscience trouva qu'elle pouvait faire mieux et plus pour société. C'est l'histoire de l'American College of Surgeons que tout le monde connait, et de son vaste programme visant à la classification des hôpitaux. Et ce sont les médecins qui battirent la marche. Les services s'organisèrent sur des bases solides, l'ère des consultations obligatoires fit son apparition, le département des archives devint en quelque sorte le miroir de l'institution, les autopsies se firent sur une plus grande échelle, parce que jugées nécessaires plus que jamais, les laboratoires réclamèrent plus d'espace, leur travail devant se continuer même après que la mort eut fait son oeuvre, dans l'espoir, disons-le, de découvrir un facteur qui serait passé inaperçu et qui demain, pourrait encoure jouer un rôle néfaste. Je pourrais le faire bien longue cette liste des superbes améliorations apportées dans les services hospitaliers depuis un quart de siècle. Je pourrais également m'étendre longuement sur la lutte héroïque livrée depuis quelques décades par le corps médical aux maladies qui faissaient tant de ravages parmi les nôtres, gastro-entérite chez l'enfant, tuberculose, typhoide, et que sais-je encore. On lisait avec plaisir dans les journaux, ces jours derniers, que la grande metropole du Canada n'avait eu à déplorer aucun décès par la diphtérie en 1953. Nous savons tous que les médecins et les chirurgiens sont des personnes très humbles et qu'ils n'aiment pas crier leurs succès sur tous les toits. Tout de même, il faut se rendre à l'évidence, et force nous est de reconnaitre le beau rôle tenu par le corps médical à l'hôpital, au dispensaire, et à la clinique, car si ces maladies n'avaient pas été enrayées, où placerions-nous leurs victimes aujourd'hui? Il nous faudrait encore 50 pourcent plus de lits que nous avons actuellement.

Eugéne W. Thibault, M.D.

Mais, me direz-vous, qu'est-ce que tout cela vient faire dans le coût d'hospitalisation, le sujet de notre entretien? Je réponds: il n'est pas un être qui puisse évaluer en dollars ou en monnaie quelconque les services rendus par le corps médical à la société toute entière dans le dernier demi-siècle, puisque c'est la période de temps qui nous intéresse présentement, pas plus qu'il n'existe une statisticien ou un actuaire qui puisse dire combien d'hôpitaux et de lits nous aurions de plus à l'heure actuelle au Canada et aux Etats-Unis, si médecins, chirurgiens, et hommes de laboratoire ne s'étaient pas donné la main pour remédier à l'état de choses existant auparavant, pour abréger la durée des maladies, pour donner son congé au malade qui a souffert de pneumonie, le douzième jour après son entrée à l'hôpital, alors qu'autrefois il séjournait un mois à l'hôpital pour la même affection, pour permettre à la femme qui a dû subir une hystérectomie de

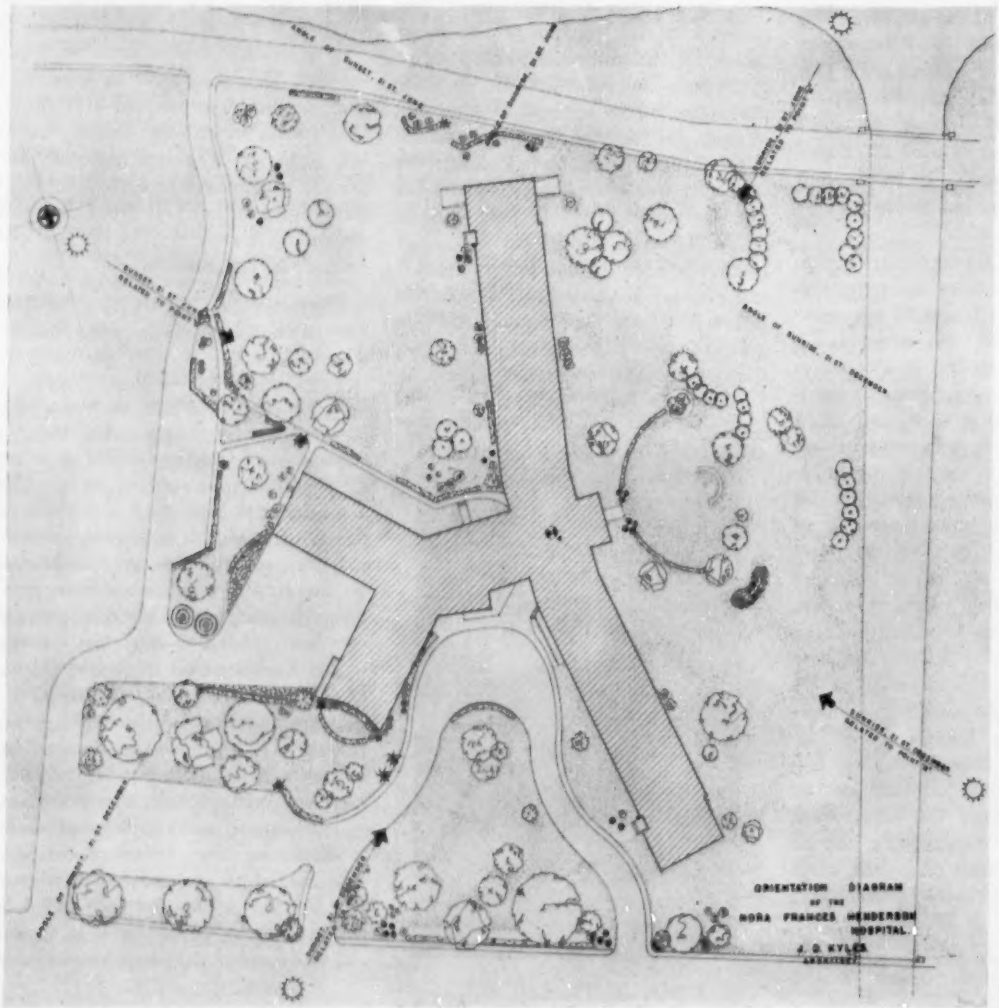
(Suite à la page 112)

Travail présenté au XXe Congrès du Comité des Hôpitaux du Québec, tenu à Québec, les 28, 29, et 30 juin, 1954.



West elevation showing the administration wing, front left, and auditorium, right centre.

Nora-Frances Henderson Hospital



A unit of the Hamilton General Hospital

J. B. Neilson, M.D.,*
Lloyd Kyles,
Hamilton, Ontario

THE Hamilton General Hospital has had the experience of providing care for an increasing number of patients who, after initial therapy, did not require many of the services supplied by a general hospital dealing primarily with acute illness. These patients were largely those who, while requiring institutional care, needed physical rehabilitation and among these were many with fractures, paralytic poliomyelitis, arthritis, apoplexy, and decompensated cardiac disease. Thinking therefore developed that if a hospital, designed to provide facilities for physical rehabilitation, could be built, considerable alleviation of acute hospital bed shortages might result. In addition, it was thought that the cost of patient care in such an institution would be considerably less than in an active treatment general hospital.

With this background of thinking, plans were developed in 1950 for the construction of a hospital which would embody the desired features. Property was available on the mountain adjacent to the existing Mount Hamilton Maternity unit and construction commenced in May 1951. By July of this year the new 338-bed Nora-Frances Henderson Hospital was ready for occupancy. A new laundry was constructed on the site, designed to serve both the Mount Hamilton and the new hospital. The boiler capacity of the power plant which had supplied heat to the Mount Hamilton unit was enlarged and heat from that source is carried to the Nora-Frances Henderson through buried steam lines. Early in the planning of the new unit, it was decided that every effort would be made to incorporate structural features which, while reasonable in cost, would decrease maintenance and operating costs of the building. For this reason a radiant heating system was installed throughout in all ceilings as well as in the exterior walls for better control. Extensive use of building tile is also part of the program for decreasing maintenance costs.

The excellent location of this hospital permitted a design which provides splendid views from practically every room and the panorama across the city and over the bay to Lake Ontario beyond is especially impressive. To take full advantage of the surrounding landscape and all possible sunlight, the main axis of the building runs due north and south. Large windows capture the outdoors and also provide a cheerful interior. For the same reason, balconies and solaria are numerous and there is a roof deck as well as extensive lawns.

Structure

The structure is comprised of the main patients' building, which is 421 feet long and five storeys in height with a smaller storey on top, and a two-storey wing which extends westward in the form of a "Y". The administration section is in the cul-de-sac which is the north-west branch of the "Y" and the auditorium extends to the south-west from the entrance section in the stem of the "Y". These wings are located thus in order to provide privacy for the business offices and easy access to the auditorium which may be used for public functions. The latter unit, with its wide stage, has all facilities for lectures, movies, plays, and concerts, and has been built with windows on the north side to provide natural lighting for day-time entertainments.

The administration and auditorium wings are of steel framework while the main building has a reinforced concrete frame with brick and tile on

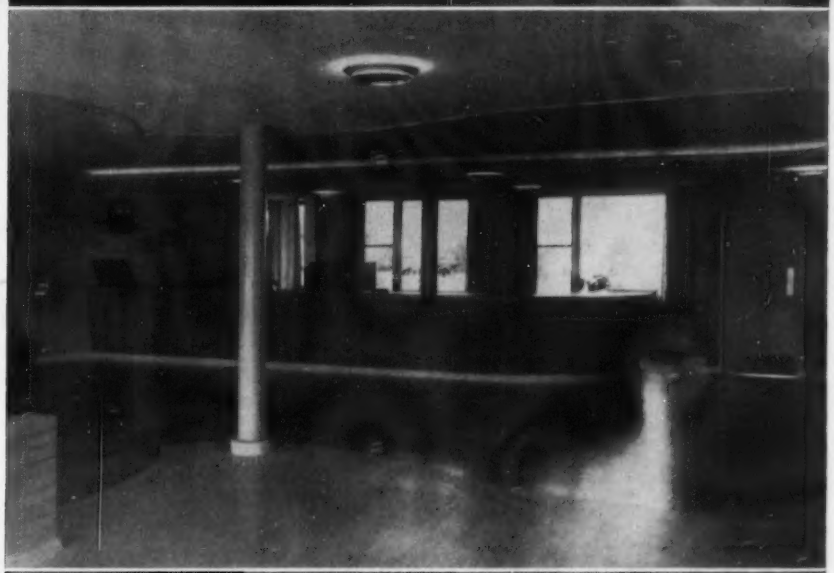
**Dr. Neilson is administrator of the Hamilton General Hospital and Mr. Kyles is a member of the firm, Kyles and Kyles, architects. This article was compiled from data submitted by both authors. Superintendent of the new unit is Miss Ada Squires.*

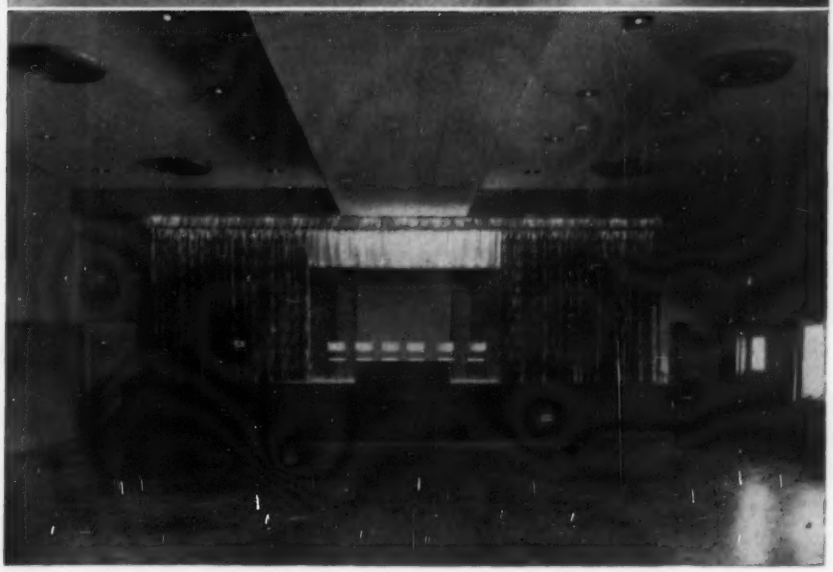
View from the northeast, indicating orientation of two long patients' wings.

Above: Lecture room. Students taking the nine months' course to become nurses' assistants, as well as other staff members, are trained here. Note equipment for instruction in nursing arts.

Centre: Nurses' station with window at rear looking into pharmacy supply cubicle. In foreground a mobile telephone unit for use of patients.

View of the spacious kitchen area with gleaming steel and tinted tile. Wide windows overlook the lawns.





Above: Front wall of the main rotunda is of glass, with protecting canopy outside the door. Foliage flourishes in a built-in bed forming a semi-partition.

Centre: Reverse view of rotunda shows reception desk, wide rear windows and the doctors' entrance. Unseen here, doors at the left of the desk lead to the administration section and the auditorium respectively.

Below: The auditorium which seats approximately 300 has the required equipment for concerts and motion pictures and is wired for television. The floor is of beautiful parquet and cupboards under the stage house the folding chairs.

On each floor is a central recreation and dining area, with a view eastward over Lake Ontario. Small tables are being provided and ambulatory patients, both men and women, may have their meals served here, enjoying the benefits of company and a pleasing atmosphere.

the exterior walls and tile interior partitions. The brick facing is light in tone with panels of coloured tile running vertically between the windows on each floor and forming the face of all balconies and sun rooms. The tiles are in deep shades on the lower floor with lighter panels of the same tone used in each successive storey in height. The colours vary on the different elevations.

Inside, room floors are of terrazzo, while corridor floors are covered with linoleum and dadoes are of tile. All window sills and showers and toilet stalls are of selected marble. Again these materials have been used for durability and easy maintenance. The hospital has been constructed so that two additional storeys can be added when required.

The driveway which enters the property from the south leads to the main entrance in the stem of the Y-shaped wing. A sheltered doorway opens into a large rotunda and waiting area, facing the information and business counter (see illustrations). Just inside the door is a gift shop and, beside the long counter, the doctors' entrance and locker room. To the left of the rotunda, doors lead to the administration section and to the auditorium. To the right, a short corridor leads past the social service rooms and washrooms to the elevator lobby in the main patients' building.

Main Building

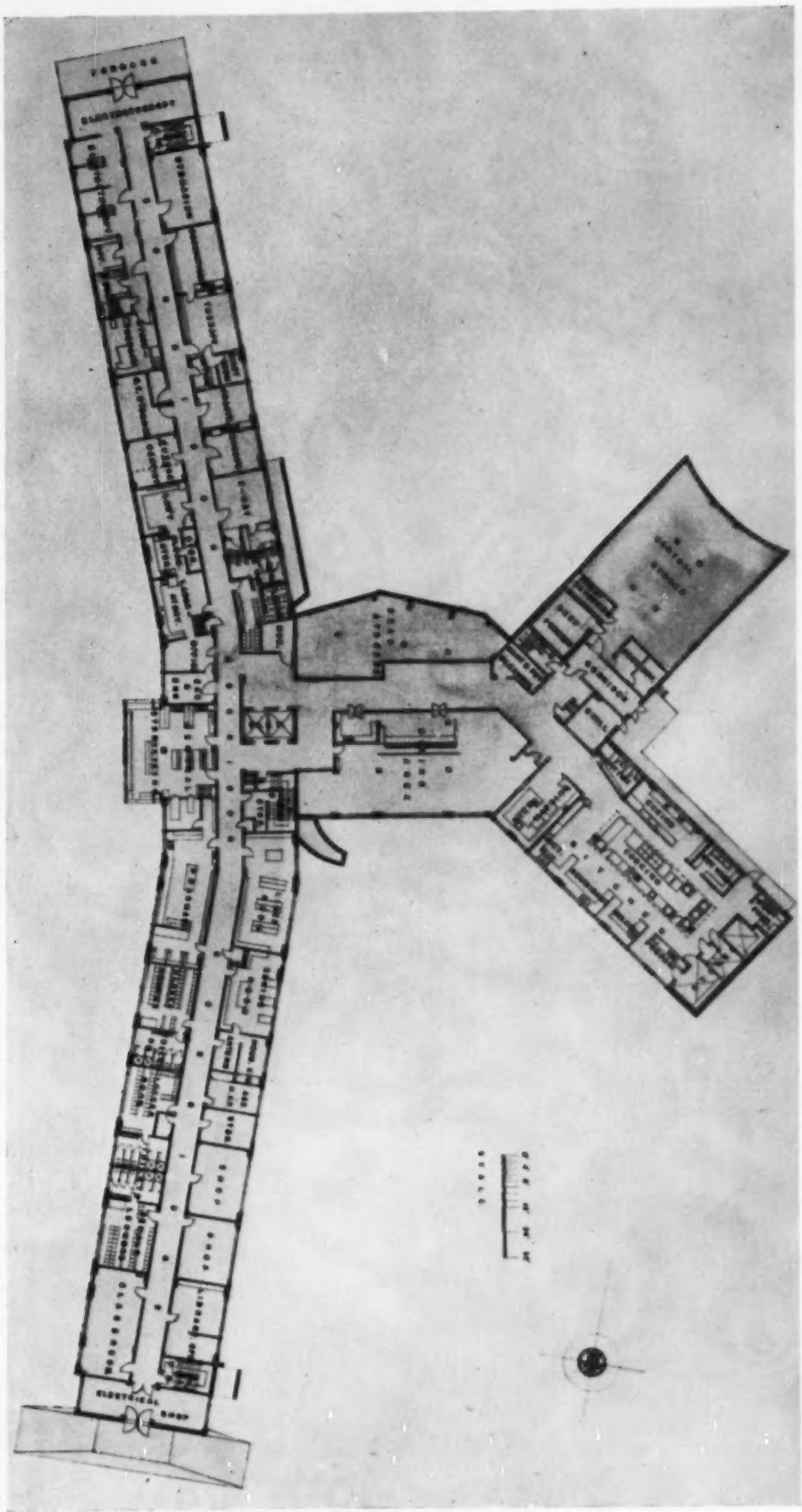
The main five-storey building houses all patients and treatment rooms. The basement or service floor is at grade level at both its north and south ends and has extensive space allocated for physical and occupational therapy. Both of these departments are well-equipped and are designed to provide service to both in-patients and out-patients. The laboratory, pharmacy, and x-ray departments are built on a generous scale and could serve the needs of a more active-treatment hospital if such a requirement should arise in the future. On this floor also is an emergency division, fracture room, dental clinic, electro-cardiograph and basal metabolism rooms, the central sterilizing department, linen rooms and the housekeeper's office. Care has been taken to provide adequate locker space for the staff as well.

The first to fourth floors, inclusive, contain the patients' rooms. The fifth was originally planned as interns' quarters but, as finished, one section of it serves as a teaching area for nursing assistants, including classrooms and laboratory. This space will also serve for other on-the-job training. The other half of the floor provides sleeping quarters for two nurses and apartments for the superintendent and the assistant superintendent.

The Nursing Unit

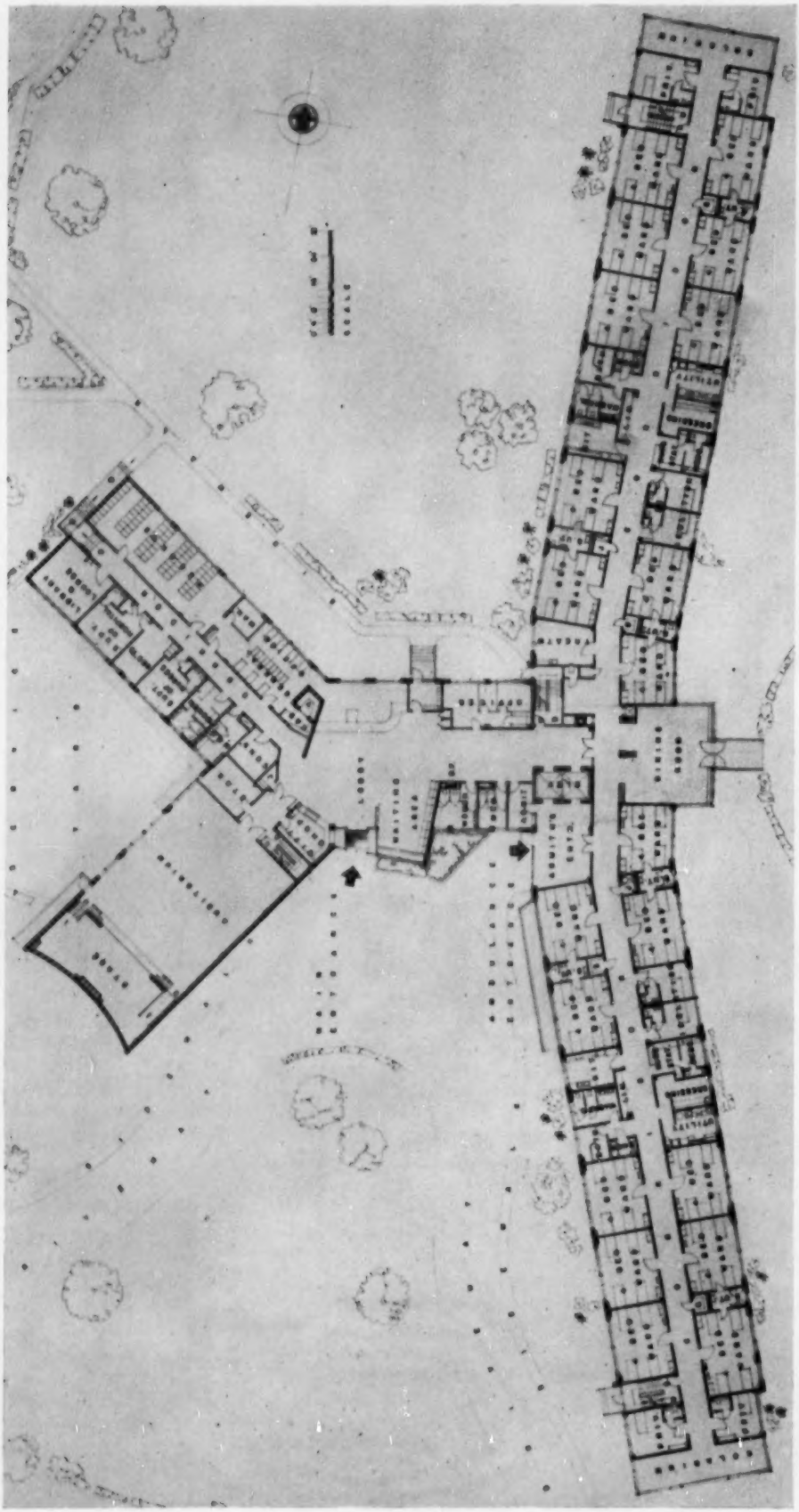
Each nursing floor is divided into two units, one for men and one for women, and each unit contains 38 to 44 beds, with a total of eight units and a bed count of 338. No room contains more than four beds and a satisfactory allocation of private, semi-private, and isolation rooms has been arranged.

The nursing station is centrally located within the unit and is connected with each bed by an audio-visual signal system. Each bed is also provided with an outlet which permits four-channel radio reception from a central source. This system can also be used for transmission of recorded music. There is a wall cupboard for each bed and each room contains a wash basin. Utility units are installed between

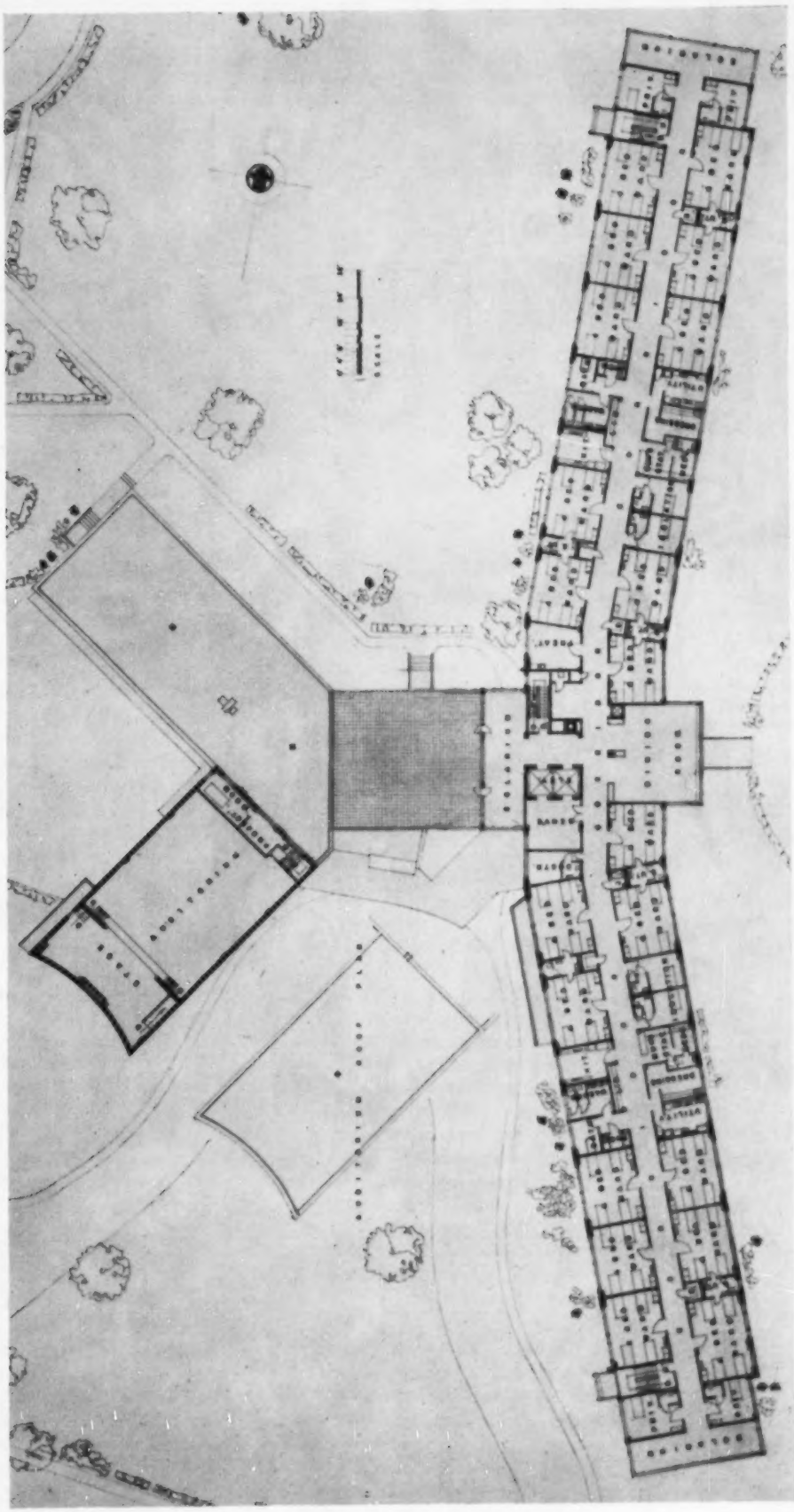


Basement

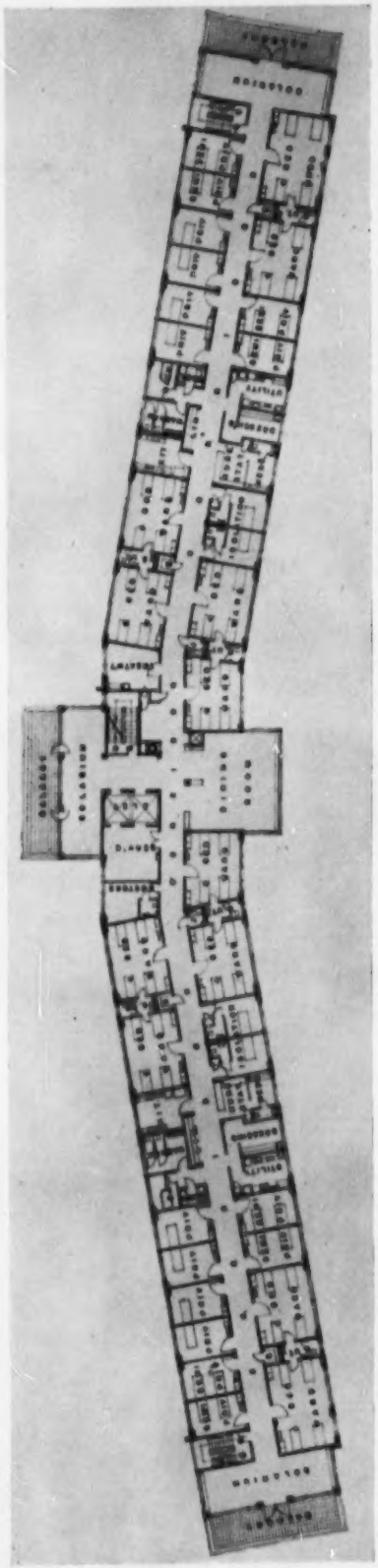
Kyles and Kyles
Architects
Hamilton, Ont.



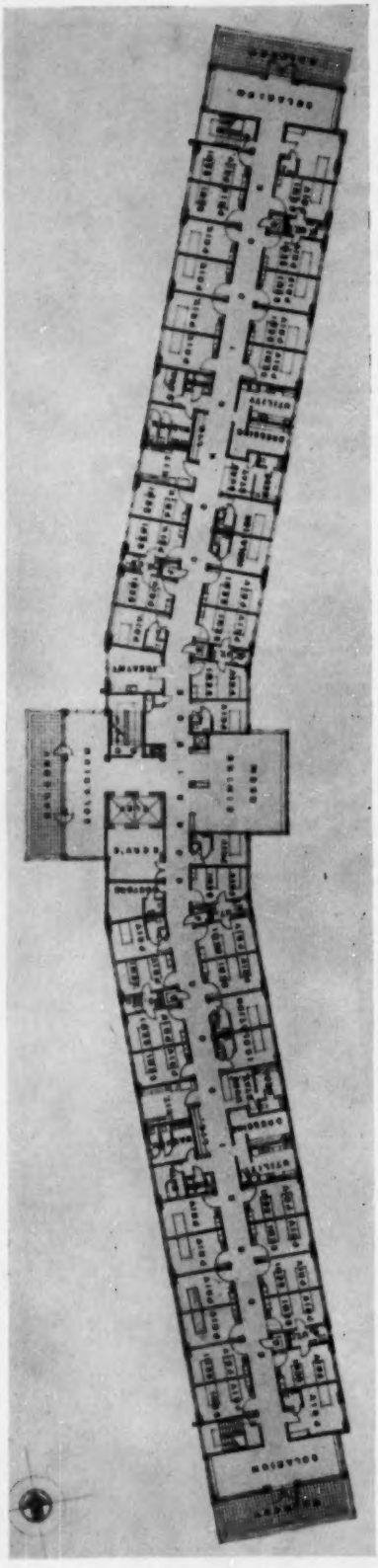
First Floor



Second Floor

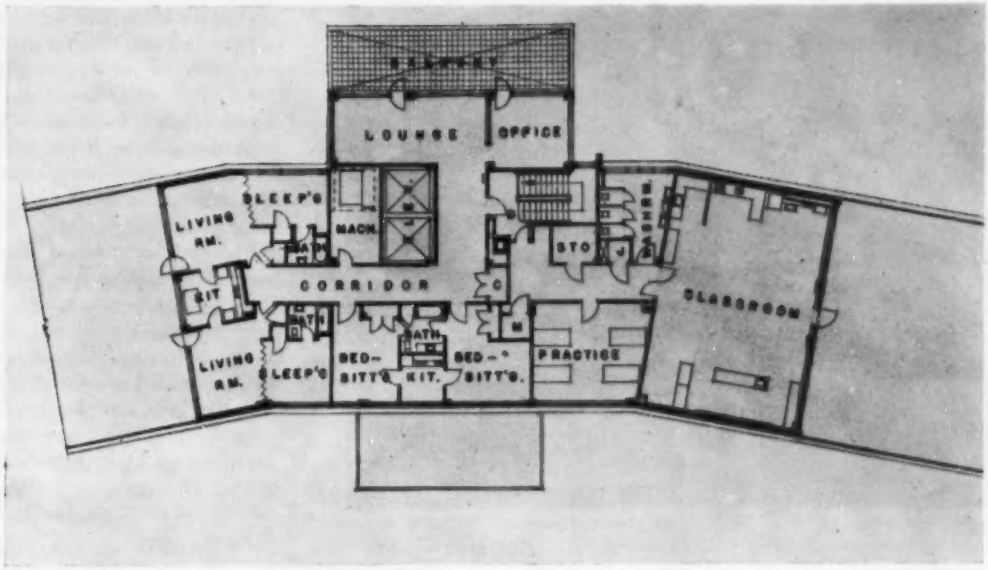


Third Floor



Fourth Floor

Kyles and Kyles
Architects,
Hamilton, Ont.



Fifth Floor

each four-bed room. The room furniture is of metal with arborite tops and is finished entirely in a light colour. Each bed has its own pair of bedsides attached to it and rubber mattresses only are used in the building. Thin sun curtains can be drawn to check glare when desired and heavy drapes have also been provided. The large double-glazed windows, set in aluminum sash, are pivoted vertically and so can be cleaned from within and are readily adjusted for ventilation. An attempt has been made in all the rooms to provide bright, comfortable and cheerful surroundings which are conducive to the well-being of the patient.

The service area in each nursing unit consists of clean and soiled utility rooms, dressing room, and ward kitchen, all adjacent to the nurses' station, opposite which is a linen cupboard. Bathroom facilities are also located centrally and these provide a free-standing bath tub, shower, water closets and low-set wash basins. All washroom and toilet compartments are designed to permit wheelchair patients to use these facilities without the help of attendants.

This central service core takes up approximately 33 lineal feet of corridor. Beyond this point in any unit, the decorating, lighting fixtures and even the floor covering are all changed in order to reduce the seeming mileage of a long corridor and introduce variety. Corridors have coloured glazed tile dadoes 4'6" high, with tinted plaster walls above and accoustic tile ceilings. Each unit has its own sun room and the upper two floors have, in addition, their own outside balconies. The north and south wings are swung 10 degrees off the main axis to terminate the long corridor and provide privacy to the separate units.

A treatment and examining room with surgeon's sink and autoclave, in addition to examining facilities, serves two nursing units, as does a small room for the physician. Each floor is connected by a dumb-waiter to the pharmacy and the central supply room in the basement.

The over-all design of the nursing floors is intended to provide comfortable accommodation but also to keep patients as active as possible. On each floor there is a common dining and social area located centrally between the men's wing at the north and the women's in the south. These pleasant rooms facing eastward over the lake are used by ambulant patients, as are also sun rooms and balconies facing west. The social and dining rooms have built-in flower boxes to add interest and beauty. Also sun rooms and balconies have heavy marble shelves to support flower boxes.

Colour

The interior of the hospital with its carefully planned décor is most attractive but, even more important, colour has been used with a view to its possible therapeutic effects. Patients able to amble to nearby rooms for short visits will enjoy a complete change of colour scheme, even in the terrazzo. There is variety everywhere.

Each patients' room has a rich colour on the wall behind the bed, with a corresponding pastel tone or a complementary tone on the other three walls. While pale tones are restful to the eyes of those who are ill, patients will enjoy the contrast when they are able to be up. Rooms with south and west exposures are in basically cool colours while those on the north and east are decorated in warmer tones. Colours used in dining rooms and solaria are different from any used in the wards, thus providing complete change.

All materials used were carefully checked for sunworthiness, durability, and the laundry maintenance factor. In some cases, manufacturing procedures were changed to obtain more serviceable materials.

Dietary Department

The dietary area is below the administration section but, as the grade falls toward the west, its large windows overlook the rolling lawn. This department includes a large and well-equipped kitchen and a cafeteria for hospital staff. There is a dishwashing unit of sufficient capacity to permit centralized washing of all dishes used in the hospital. Serious consideration was given to various methods of food service and, at the present time, a central system is almost completed. It is designed around a conveyor belt

(Concluded on page 102)

What of the Night?

Part 1

SINCE THE HOSPITAL is open 24 hours a day, the same quality of care and efficiency of administration should prevail during the hours of darkness as is in evidence during the normal working day. All too often, the night direction of the hospital is, to all intents and purposes, ignored or else is placed in the hands of a person who does not have the administrative attributes necessary for the position.

While every hospital, regardless of size, functions at least on a reduced scale during the night hours, efficient night administration is perhaps a problem of greater concern to the larger institutions than to the smaller hospital which may have relatively few departments in operation on a 24-hour basis.

Throughout the hospital world, in institutions of 500 beds or more, practically every department is manned on a full-time basis and the number of personnel on duty in the hospital on the evening and night shifts may well run into hundreds. Remember, nearly one-third of the total personnel complement of the hospital is employed for one of the two night shifts.

The era is long past when patients were simply sedated and put to bed for the night to await the normal duty hours for continuation of treatment. The advent of antibiotics, chemotherapy, and other advances in therapeutics have altered the care of patients, mechanically as well as medically. Modern developments in medicine alone have brought changes in the principles of administration of these medications to a 24-hour program, causing a chain reaction throughout the hospital.

Personnel at Night

This one facet of patient care has produced repercussions among personnel. It is now necessary to have more graduate nurses on duty at night to administer these modern therapeutic agents. The very fact that these drugs are given has an effect in the laboratory—more technicians are required to perform procedures incident to proper treatment and control of the patient. In all probability, the pharmacy as well as central supply has also been involved in this one problem.

If the night functions of the hospital involved only the medical and nursing divisions, there would be much less cause to be concerned with night administration. Consider for a moment, the various classifications of personnel needed to operate a large hospital at night. The majority of night workers are under the nursing service: nurses, aides, and orderlies. But, there are many others. Laboratory and x-ray departments must function completely; oxygen therapy is on constant service; the business offices have a routine night procedure for posting and auditing; admitting and information services must always be open and, in a large government hospital, social service workers are on call. Let us not forget, as many do, that these people have to be fed a meal at night; therefore, facilities and personnel are necessary to give complete meal service. Maintenance and housekeeping personnel also are essential for the overall operation of the hospital.

It becomes apparent that in the large hospital competent night direction is needed. The custom that prevails in most hospitals of utilizing the night nursing supervisor as the night director is antiquated and deplorable from a management viewpoint. The nursing supervisor is generally fully occupied with the duties directly originating from the nursing service and as a rule has little time or inclination to concern herself adequately with the multitude of situations which occur. It behooves management to have a representative on the scene at night who can handle every problem which may arise without recourse to the daytime administrative staff.

The Night Director Should Be . . .

The night director should be capable, with authority to administer the policies of the hospital and to act in place of the hospital director. Obviously, this person must enjoy the fullest confidence and trust of the hospital director. The night director, in brief, should have those qualifications and attributes that are recognized as being essential for any hospital director and which have been so aptly detailed by Dr. Malcolm T. MacEachern, in *Hospital Organization and Management.*

The night administrator should be a person who knows the hospital intimately and who is able to interpret to the employees the public policies and rules of the hospital. He must be a person who is anxious to see night administration improved, a leader who is not unwilling to sacrifice much of his own personal time to accomplish this end.

From a thesis prepared for the Department of Hospital Administration, School of Hygiene, University of Toronto, Toronto, Ont. Mr. Doney, Jr., gathered his material during his administrative residency at the Jackson Memorial Hospital, Miami, Florida.

Joseph J. Doney, Jr.,
Memorial Hospital Association of Kentucky, Inc., Washington, D.C.

The large institutions have an admirable and enviable source of night administrators in their administrative residents. It would be well for those hospitals to consider enlarging the scope of the administrative residency program so that it includes a second year as the night director. The resident will satisfy all of the requirements for the position and it will be of benefit to him as well as to the hospital.

Probably it would be impossible to keep the trained administrator in such a post for a period longer than one year. As part of the administrative residency program, a constant source of assistants with the required desirable qualifications could be available. Naturally, there are other well-recognized systems of promotion from within the hospital that would provide permanent night directors.

His Roles

From the standpoint of administration, the night director is faced with a situation that is somewhat unique. While his line of authority should extend directly from the hospital director, his purpose is not to establish a second hierarchy, nor a dual administration to conflict with the recognized organization of the hospital.

The night director must recognize that his main function is to co-ordinate the night and day operation of the hospital departments. He should act as the substitute department head for every department in operation as well as for the hospital director. Therefore, it is absolutely essential that he has a proper regard for the department head when he makes a decision. There must be a complete spirit of co-operation and trust between the departmental heads and the night director; otherwise, they can constantly be at odds with each other and the employees will be caught in the middle of an undesirable situation caused by conflicting orders and instructions.

While it is extremely desirable to maintain a harmonious relationship with the departmental heads, this does not preclude the introduction of new practices to increase efficiency in the night operation of any of these departments. However, the night director must work with and through the departmental head to initiate any changes in night operation.

There has been an unfortunate tendency in most hospitals to allow a breakdown in communication to occur between the day and the night forces. The night director can do much to obliterate this situation, provided he is willing to expend some of his personal time. It is imperative that the night director attend the department head meetings, as well as staff meetings and other special meetings that are of general import. He must form the link that does not break in the chain of communications.

One of the chief reasons for having a well-trained night director with delegated authority is to provide a person at all times who can and will make an administrative decision. If every problem is to be deferred or if it is necessary to contact the other administrative assistants for every decision, then there is little value in having a night director.

Problems Arising at Night

Any number of diversified problems and situations can and do arise during the night hours. A large number of these problems will have direct bearing on the hospital's public relations program. Because he is on the scene during the visiting hours, the night director will have to deal with a large number of persons who would ordinarily be referred to the hospital director in the morning. At this hospital, all communications to the newspapers and radio commentators are referred to the night director, as he is generally on duty when this information is obtained by the news gathering agencies.

With his knowledge of personnel policies, the night director can answer many of the questions of his night force and counsel many of the employees who cannot or will not go to the personnel office during the day. These people should not be neglected.

One of the most important tasks of the night director will be to handle problems arising from the medical and house staff which would ordinarily be referred to the medical director. Here, as with most of the situations which arise at night, a decision is demanded and required immediately. Again, this points out the need for the night director to be well-informed and cognizant of medical regulations and rulings as they pertain to his hospital.

Each day it is necessary that the night director render a written report to the hospital director concerning any critical situations he feels may have arisen. He should also have free access to the executive and medical directors each day to discuss his actions and to make recommendations.

"On-Call" Night Coverage

The methods by which a specific hospital can provide adequate night coverage is, of necessity, predicated on a large number of circumstantial factors which provides several alternates or modifications that may be applied to the individual hospital.

The size of the hospital and its resulting personnel force is probably the most dominant factor. A smaller hospital would not necessarily be required to provide the magnitude and diversity of night coverage that a larger institution would have the onus of providing. Other than the nursing services, adequate coverage may be and usually is provided by an "on-call" schedule of personnel concerned with various departments. The administrator himself usually feels that he must be on call for those administrative decisions which arise during the night.

Generally, in the small hospital, departments and responsibilities have been combined so that fewer individuals are concerned with the problems of coverage. The laboratory, radiology and electrocardiology services, for instance, may be handled by one person who will answer the infrequent calls for any of these divisions of clinical methodology. It is quite improbable that a permanent night director, other than the nursing supervisor would be required in the small hospitals.

The community environment can also be a factor in considering night coverage. If the hospital is the only medical institution in the locality, it may be necessary to provide a more complete night coverage in order to care for a higher average number of emergency admissions.

Between the two extremes of having only "on-call" coverage for all departments other than nursing service or maintaining a completely functioning hospital at night, there will be many variations and modifications which can be developed to suit the requirements of a specific unit or hospital. It may well be that personnel quotas, operating costs, demand for special services, administrative techniques, and many other intrinsic and less obvious factors must be considered in

(Concluded on page 90)

Setting the stage for Community Assistance

The successful public relations project at Oakville-Trafalgar Memorial Hospital won first prize in the 1954 competition sponsored by *Hospital Management.*

A Community public relations program, which won for the Oakville-Trafalgar Memorial Hospital, Oakville, Ont., this year's first prize award in the continent-wide public relations competition sponsored by *Hospital Management*, is one which deserves a good deal of attention. The hospital, situated in a small rural town midway between two of Canada's largest industrial centres, Toronto and Hamilton, was built in 1950, with 44 beds to serve a primary area of 10,000. Due to rapid industrialization, the hospital must now serve over 17,000. Since the community had borne the cost of building a new hospital only a few years previously, the people of the district had reason to believe that expansion would not be necessary for some time. However, as the population continued to grow rapidly, the hospital's governors realized they would again have to turn to the community, in the near future, for financial support.

As it was felt that a sound understanding of community responsibility had to exist before a fund-raising campaign could hope to succeed, the hospital obtained the services of a public relations man. Sydney N. Lambert, manager of public relations for the Goodyear Tire and Rubber Co. of Canada Ltd., was asked to join the hospital's board of governors. Mr. Lambert not only serves on a voluntary basis but his company has given him every encouragement and provided facilities to help him.

A one-man committee, Mr. Lambert set out to organize his program on the following principles: (a) a realistic employee relations' policy would be adopted to maintain high staff morale; (b) an orthodox program of advertising and publicity should proceed; and (c) great concentration would be given to the factor of personal participation in hospital activity and affairs by people of the community.

Objectives

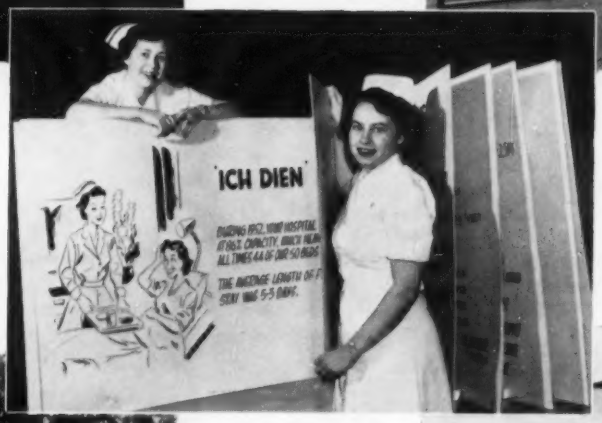
The first objective of the program was to keep long-time residents advised of Oakville-Trafalgar Memorial Hospital (O.T.M.H.) activities and to maintain their interest, as well as physical and monetary support. The program was also aimed at making newcomers aware of the hospital and its services. Other objectives were to maintain high staff morale, to inform local business and industry of the hospital's value to the community, and to explain hospital policy to all residents, thus setting the stage for a successful capital fund drive.

Since so much of good hospital public relations comes from within the hospital itself and evolves around good staff relations, emphasis was placed on this aspect of the program. Through the development of an excellent salary structure, good selection and placement methods, merit rating, contributory pension and insurance, employee benefits, living accommodation, et cetera, the hospital has been assured of high morale and low employee turnover. The staff has given its complete support to the board's policies and plans and has proved of the greatest aid in each phase of the program.

General Publicity

For general publicity newspapers, of course, offer an excellent means of keeping the public informed. The Oakville area is served by two weekly newspapers, each with a circulation of approximately 3,500. In addition, three metropolitan daily papers from Toronto and one from Hamilton are widely circulated in the area. This created a number of publicity problems, chiefly concerning release dates. It had been the hospital's policy to release news simultaneously to the metropolitan and weekly papers. Because it is considered important to have all directors' meetings covered by the press, these meetings were changed from Thursday to Tuesday so that the local weeklies would have the same news breaks as the metropolitan dailies. Radio newsrooms receive all hospital press releases and 15 stations reaching the area often carry items on the hospital.

News stories released to the papers cover meetings and human interest stories. Key personnel on duty in the hospital have been trained in basic press relations and co-operate in keep-



Posters and displays, such as pictured top left, centre, and bottom left, attract attention of local residents to the hospital.

Top right, exhibits in stores and business buildings provide good publicity. Below right, women's auxiliary takes over when food elevator breaks down.

ing the press informed. Since the primary obligation of the hospital is to the patient, news releases do not mention patients' names unless clearance has been granted by the patient. Many accident cases are brought to the hospital, which is located near a busy highway. The hospital's policy regarding names has been fully explained to the press men, who are not allowed to bring cameras into the hospital, and this policy is carried out to the letter.

Advertising

In carrying out its policy of keeping the public informed, the hospital uses paid advertising space whenever it is felt that a message can be more effectively explained through this means. Semi-annual and annual reports are published in this way. Every second week, from January to May, the hospital record is published. Paid notices for the annual meeting, memorial fund, and advertisements for other functions such as the garden tour are also purchased.

The hospital also takes every opportunity to avail itself of free advertising space. Twice a year the hospital has the use of free booth space at local fairs. These exhibits enable the hospital to demonstrate what new equipment is needed and what future plans for the hospital have been made. Booths are designed so that all material may later be used in window displays. And several opportunities occur each year for this type of display.

The O.T.M.H. runs two direct mail campaigns for membership each year, the first campaign soliciting industrial membership, the second, individual membership. An objective of this campaign is to raise funds through membership in the local hospital association. The association has been in existence for four years. When this phase of public relations was started, there were 17 members in the association donating approximately $225. Today, there are 575 and membership donations now amount to approximately $12,000 each year.

Annual Meeting

In 1954, the hospital presented its annual report as an advertisement in one of the local papers. Extra copies of the advertisement were folded into a "flyer" and distributed through post office facilities to more than 7,000 residents. Using this method, potential readership was projected to 20,000 persons at a cost of $600. Personal invitations were sent to all hospital subscribers, health officials at provincial and federal levels, and opinion group leaders within the area. Pre-meeting publicity took the form of an animated window display, which was set up in a local store urging the residents to attend the meeting to serve as judge and jury at the "Court of Inquiry" to be held by the board of governors.

The meeting was held in the Oakville arena and attended by 350 persons. It was covered by newspapers and a Hamilton radio station made a public service broadcast of the annual report presentation. The publicity resulting from this meeting was exceptionally good and public reaction extremely favourable. The Hospital Tag Day, held the following week, netted more than $1,500, three times the proceeds of a similar tag day held the previous year. Much of the success of the day was credited to the enthusiasm generated by the dramatic presentation of the annual report.

Women's Auxiliary

The women's auxiliary has ever been a source of valuable voluntary aid to the hospital, as well as contributing greatly to good public relations. Some 240 volunteers work arduously for the hospital. They save operational costs in the supply room up to $1,725 per year, provide linen and sew at one-third of the cost, arrange flowers saving 24 nursing-assistant hours per week, are a source of stand-by help in cases of emergencies, and undertake other fund-raising aids. One of the big projects of the year is the Garden Tour. At this time, five lovely estates along Lake Ontario are open for public inspection. All proceeds from the tour are used to buy new equipment. The 1954 tour grossed more than $4,000 and the money will be used to

Certificates of membership in the local hospital associaton are issued in attractive frames. Right, a scroll, with the names of business firms contributing to the hospital, is posted in a prominent place.

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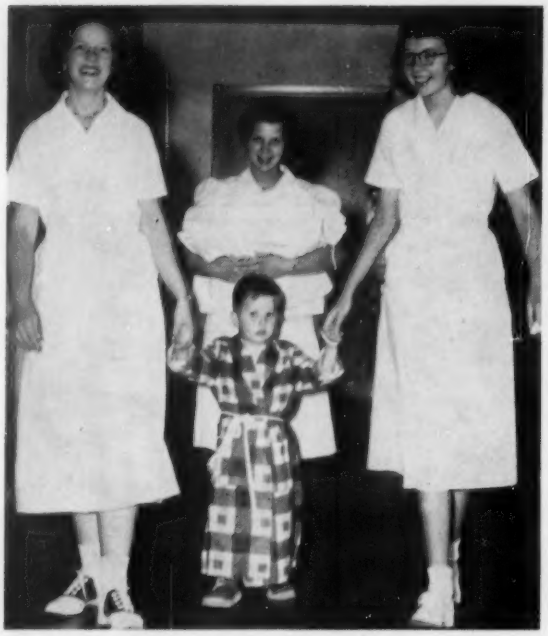

Human interest pictures and stories are sent to local newspapers

equip a new nursery that has just been built.

Other Special Projects

Another special event which keeps the hospital before the public's eye is Career Day. High school students interested in hospital careers are shown through the institution and supervisors explain the work of the various departments. During the summer, eight positions for nurses' aides are open at the hospital. As a result of the efforts on behalf of the students, applications for these positions are plentiful.

A one-man speakers' bureau is carried on by the chairman of public relations. Many local clubs and service organizations are contacted and Mr. Lambert has delivered a number of illustrated talks to these groups. He has also addressed several out-of-town organizations. Many favourable results have been obtained from these talks. The Lion's Club of Oakville has pledged $22,000 over a three-year period for a new paediatrics ward; the I.O.D.E. is donating $600 each year toward upkeep of the hospital; and the High School Junior Red Cross contributed $300.

A "Memorial Fund" (donations of money which would ordinarily be spent to purchase flowers and wreaths) had been in existence for two years before it was decided to give it some publicity. During this period, 12 gifts were received with a total value of $107. Since early June, when the "Fund" was made known to the hospital association members, 17 gifts have been received totalling $270. Acknowledgments are sent to the donor and to the next-of-kin informing them of the donation to the hospital. Names of donors and those remembered are recorded in a remembrance book.

Special membership campaign letterhead was designed and this gave added appeal to correspondence which was sent out on behalf of the hospital. Another undertaking is the regularly issued bulletin, *News of Your Hospital*, which is distributed widely. About 20,000 book matches, decorated with the hospital's crest, were sold to stores for re-sale at cost price. New street signs were designed with the hospital's crest and placed in the town. These will remain as a perment reminder to both residents and non-residents of the hospital's existence.

Conclusion

Expenditures on public relations have amounted to approximately $5,000. This sum, however, does not reflect costs which were absorbed by various firms and organizations. All hospitals enjoy special situations and opportunities of which they can and should take advantage. O.T.M.H. has carefuly cultivated sources of supply and, as a result, has received a great deal of "in kind" support, special rates, subsidized printing, eta cetera. Estimated costs for the program are about twice the actual costs.

In the words of the chairman of the board, T. C. Chisholm, "The results we have obtained from our program have more than justified our decision to set up an operating budget for public relations. We can attribute directly to the public relations program $60,000 in donations during the year. More important, the hospital now enjoys the personal interest and understanding of a majority of our local residents." ●

Booths set up at special community functions explain the hospital's needs.

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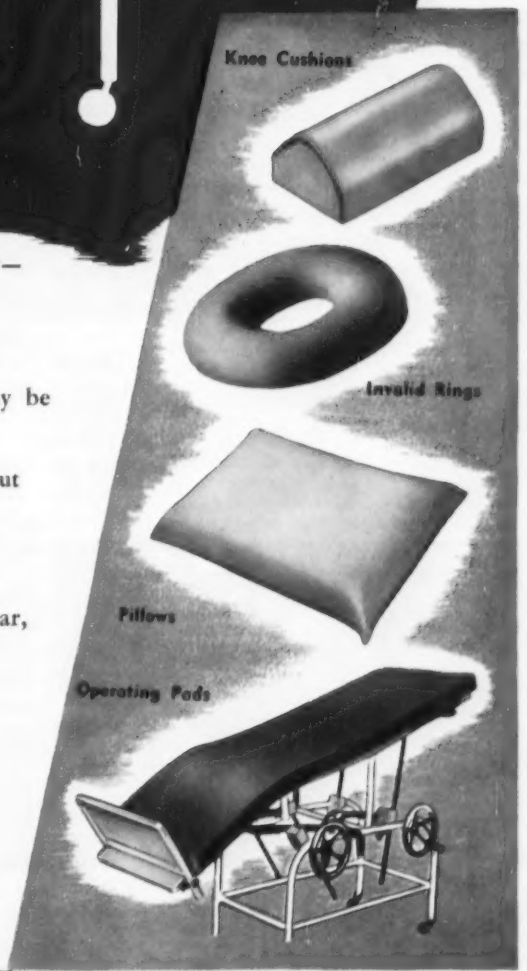

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A.C.H.A. Convocation

THE TWENTIETH annual meeting of the American College of Hospital Administrators was held in Chicago, Ill., from Sept. 11th to 15th. On Sept. 12th, the College held its convocation ceremony, with traditional dignity and splendour. Fifty-four members were admitted to fellowship, three of whom were Canadians; 222 nominees became members, including 14 Canadians; and 284 were admitted to nomineeship, of whom 17 were Canadians. A. C. Kerlikowske, M.D., president-elect, presented the candidates, while Merrill F. Steele, M.D., president, conferred the honours.

In the evening, the annual banquet of the American College of Hospital Administrators was held. The program featured an address by Louis M. Hacker, dean of the school of general studies, Columbia University, N.Y. Dr. Steele gave the presidential message and Fraser D. Mooney, M.D., past-president, was presented with the president's emblem.

"Perspective for Administration" was the topic chosen for the Bachmeyer address this year. It was delivered on Sept. 13th, by A. A. Suppan, Ph.D., professor of literature at Milwaukee State Teachers College, Milwaukee, Wisconsin.

Among those advanced in or admitted to the American College of Hospital Administrators were the following Canadians.

Advanced to Fellowship

J. Ralph Boutin, M.D., medical director, Hôpital Notre Dame, Montreal, P.Q.

D. R. Easton, M.D., superintendent, Royal Alexandra Hospital, Edmonton, Alta.

Sister M. Louise, superintendent, St. Joseph's Hospital, Toronto, Ont.

Advanced to Membership

Herbert E. Appleyard, M.D., superintendent, Regina General Hospital, Regina, Sask.

R. Ray Copeland, administrator, Port Colborne General Hospital, Port Colborne, Ont.

Vera B. Eidt, superintendent, Trail-Tadanac Hospital, Trail, B.C.

Walter Engelstad, general administrator, Grace Dart Hospital, Montreal, P.Q.

Hugo T. Ewart, M.D., medical superintendent, Mountain Sanatorium, Hamilton, Ont.

Sister M. Honora, St. Michael's Hospital, Toronto, Ont.

Frederic G. Hubbard, assistant director, Vancouver General Hospital, Vancouver, B.C.

Flora M. Lamont, director, Shriners' Hospital for Crippled Children, Montreal, P.Q.

Robert W. Longmore, assistant superintendent (administration), Toronto General Hospital, Toronto, Ont.

Stanley William Martin, associate executive secretary-treasurer, Ontario Hospital Association, Toronto, Ont.

Sister Maura, superintendent, St. Michael's Hospital, Toronto, Ont.

John B. Neilson, M.D., superintendent, Hamilton General Hospital, Hamilton, Ont.

Sister Ste. Solange, administrator, Hôpital Saint François d'Assise, Quebec City, P.Q.

Clarence A. Wicks, M.D., superintendent, Toronto Hospital for Tuberculosis, Weston, Ont.

Nominees

Leon Bennet-Alder, superintendent, Victoria Hospital, Wininpeg, Man.

Sister Bernadette Bezaire, superior, Edmonton General Hospital, Edmonton, Alta.

Sister Cecile Maurice, superintendent, St. Boniface Sanatorium, St. Vital, Man.

Werner F. O. Daeschel, administrative assistant, Kingston General Hospital, Kingston, Ont.

Sister Gerard-Majella, administrator, Hôpital de l'Enfant Jésus, Quebec City, P.Q.

Oren W. Govier, Vancouver General Hospital, Vancouver, B.C.

William A. Holland, superintendent, Oshawa General Hospital, Oshawa, Ont.

Sister Jeanne Quintal, St. Paul's Hospital, Saskatoon, Sask.

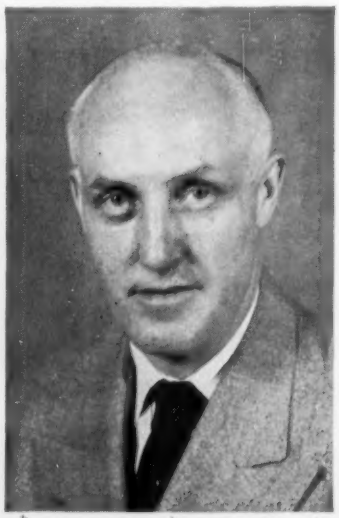
John MacKay, administrator, Lethbridge Municipal Hospital, Lethbridge, Alta.

Sister Mary Angelus, administrator, St. Joseph's Hospital, Victoria, B.C.

Sister Mary Elizabeth, superintendent, St. Peter's Hospital, Melville, Sask.

(Continued on page 58)

J. Ralph Boutin, M.D., Montreal, P.Q.



D. R. Easton, M.D., Edmonton, Alta.

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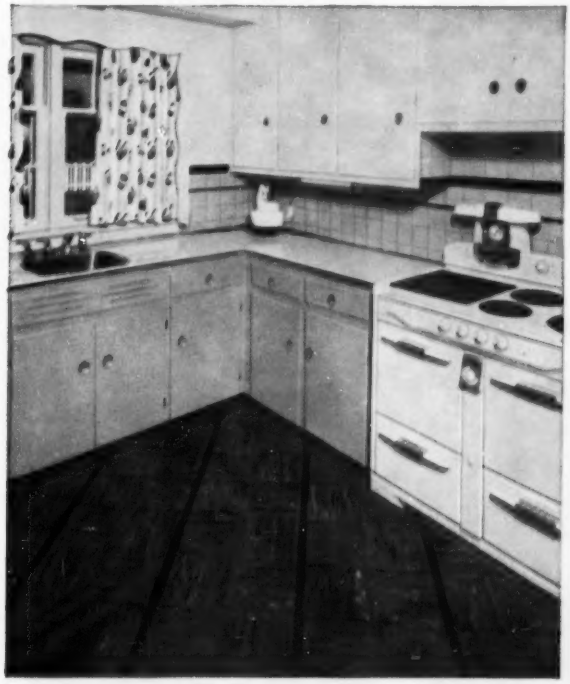

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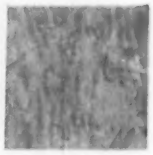

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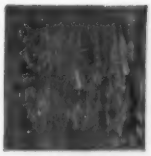
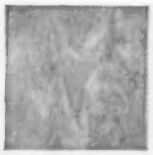


5450—GREY DAWN



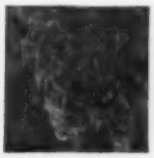
5456—MAIZE

5457—BLACK-WHITE

5454—PINEFROST GREEN

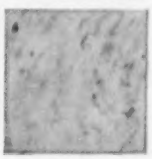
5455—CINNAMON

5453—BRICK RED



5460—DUSTY GREY

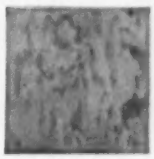
5461—SANDALWOOD



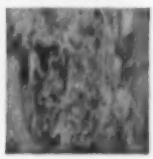
5458—WHITE-BLACK

5459—FIESTA RED

Not shown: 5365 Congo Brown, 5468 White-Red, 5367 Shell Grey, 5366 Gulf Green.



5462—EGGSHELL



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A.C.H.A. Convocation

(Continued from page 56)

Sister Mary of Good Counsel, administrator, Charlottetown Hospital, Charlottetown, P.E.I.

J. B. A. Mickie, business manager, Ste. Anne's Hospital, Ste. Anne de Bellevue, P.Q.

Kenneth M. Nicholson, administrator, Jeffrey Hale's Hospital, Quebec City, P.Q.

Elmer W. Roeder, administrator, Alexandra Hospital, Ingersoll, Ont.

Mother Ste. Thérèse, superintendent, Hôtel Dieu de St. Joseph, Bathurst, N.B.

Edward Wilson, M.D., superintendent, St. John's General Hospital, St. John's, Nfld.

(Continued on page 60)

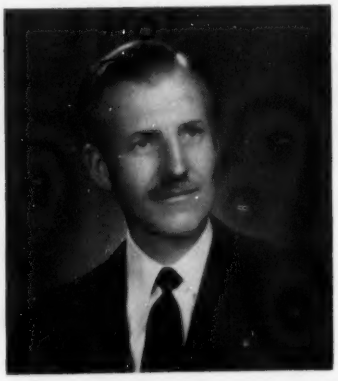
Among Those Advanced to Membership

Vera B. Eidt,
Trail, B.C.

C. A Wicks, M.D.,
Weston, Ont.

H. E. Appleyard, M.D.
Regina, Sask.

Walter T. Engelstad,
Montreal, P.Q.



Stanley W. Martin,
Toronto, Ont.

R. Ray Copeland,
Port Colborne, Ont.

Hugo T. Ewart,
Hamilton, Ont.

Robert W. Longmore,
Toronto, Ont.

A.C.H.A. Convocation

(Continued from page 58)

Sr. Ste. Solange,
Quebec City, P.Q.

J. B. Neilson, M.D.,
Hamilton, Ont.

F. G. Hubbard,
Vancouver, B.C.

Among the Nominees

Sr. B. Bezaire,
Edmonton, Alta.

J. B. A. Mickie,
Ste. Anne de Bellevue, P.Q.

Mother Ste. Thérèse,
Bathurst, N.B.

Sr. Mary Elizabeth,
Melville, Sask.

Werner F. Daeschel
Kingston, Ont.

Leon Bennet-Alder,
Winnipeg, Man.

(Concluded on page 62)

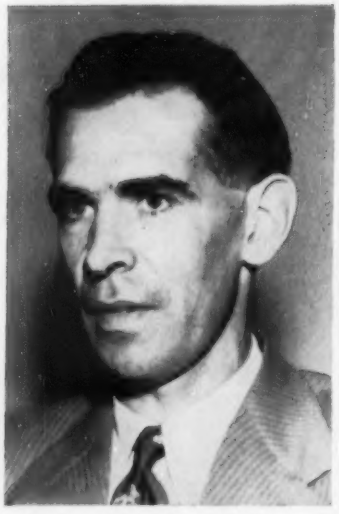
A.C.H.A. Nominees

(Concluded from page 60)

Kenneth M. Nicholson,
Quebec City, P.Q.

Sr. Mary Angelus,
Victoria, B.C.

Sr. Jeanne Quintal,
Saskatoon, Sask



John MacKay
Lethbridge, Alberta

E. W. Roeder,
Ingersoll, Ont.

Radioactive Isotopes Used in Study of Vaccine

In several studies of problems concerning BCG vaccinations against tuberculosis, scientists at the International Children's Centre in Paris are using radioactive substances — fruits of the peaceful use of atomic science— as research tools.

One scientist, for example, is studying ways of using a radioactive form (isotope) of phosphorus and radioactive carbon to show whether a certain specimen of BCG vaccine is living or dead. This study, the report explains, is based on indications that only living BCG picks up radioactivity, whereas BCG that has been dead for even an hour does not. After the specimen has been exposed to the radioactive substance according to a certain procedure, a Geiger-Muller Counter is used to measure the radioactivity that has been picked up. Results so far obtained, the report states, justify the assumption "that radioactivity techniques are a means of distinguishing between living and dead bacilli".

Under another technique that is being investigated, "radio-autographs" will be sought to show whether a BCG specimen is living. Specimens of BCG treated with radioactive phosphorus and radioactive carbon will be exposed to film; if a specimen picks up radioactivity, it will send out rays that will register on the sensitive film and thus in effect write its autograph to identify itself as living BCG.

The research staff also hopes to use radioactive carbon as a "tracer" to show how the BCG vaccine bacilli travel to various organs and accumulate there when injected in different ways (for example, into the veins or into the skin of animals). When the radioactive substance is injected with the vaccine, the time elapsing before radioactivity appears in the various organs can be measured. Thus the radioactive isotope would label the position of vaccine which otherwise would be invisible inside the body. The Centre's research program is concentrated on problems related to vaccination against tuberculosis and whooping cough. — *UN Department of Public Information.*

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Students Complete First Year of Extension Course in Medical Records

WITH THE demand for trained medical record librarians mounting, the Canadian Association of Medical Record Librarians and the Canadian Hospital Association joined forces in February, 1953, to seek a solution to the shortage. Their contribution was to provide further training to personnel already working in medical record departments in hospitals across Canada. The venture took the form of a two-year extension course of 32 lessons, with two intra-mural sessions, each consisting of four weeks of practical experience in a hospital medical record department, under the guidance of a registered medical record librarian. Welcome financial assistance was given by the W. K. Kellogg Foundation of Battle Creek, Mich. Lessons were prepared and students were enrolled for the first class which commenced in the fall of 1953. At the end of this summer, the group finished the first part of the course—16 lessons, and an intra-mural session—and will receive first-year certificates. The majority plan to proceed with the second year and, upon successful completion, will be entitled to a certificate of achievement, signifying that they have taken the entire, two-year course. Then, if they meet all the registration requirements of the Canadian Association of Medical Record Librarians and have spent at least three years in a medical record department, they may apply to write the examinations set by the C.A.M.R.L. which lead to registration. Response to the two-year extension course has been very favourable. That it is filling a need is evident by the large number of students enrolled for the new class commencing this fall.

Those who have completed the first year of the course are:

Mrs. V .Noble, West Coast General Hospital, Port Alberni, B.C.

E. O. DeKelver, Vancouver Island Chest Centre, Victoria, B.C.

Sister Mary Catherine, St Joseph's Hospital, Victoria, B.C.

D. M. Miller, Royal Jubilee Hospital, Victoria, B.C.

P. Kostick, Colonel Belcher Hospital, Calgary, Alta.

Sister Mary Geralda St. Mary's Hospital, Camrose, Alta.

Sister M. Eleanor, St. Joseph's Hospital, Macklin, Sask.

Sister Mary Anna, Providence Hospital, Moose Jaw, Sask.

M. E. Sim, St. Thérèse Hospital, Tisdale, Sask.

Mavis Scott, Deer Lodge Hospital, Winnipeg, Man.

Mrs. S. Kelleher, Belleville General Hospital, Belleville, Ont.

W. Fair, Public General Hospital, Chatham, Ont.

G. E. Carter, Cornwall General Hospital, Cornwall, Ont.

Sister M. Antoinette, St. Joseph's General Hospital, North Bay, Ont.

M. A. Toews, St. Catharines General Hospital, St. Catharines, Ont.

R. Chadwick, Norfolk General Hospital, Simcoe, Ont.

Sister M. St. Joseph, Sudbury General Hospital, Sudbury, Ont.

Mrs. Martha Offord, Welland County General Hospital, Welland, Ont.

R. St. John, St. Mary's Hospital, Montreal, P.Q.

J. Gauthier, Hôpital St Luc, Montreal.

M. E. Carroll, Royal Victoria Hospital, Montreal, P.Q.

E. Banks, Barrie Memorial Hospital, Ormstown, P.Q.

Sister St. Thérèse, Hôtel Dieu St. Michèle, Roberval, P.Q.

Sister St. Andre, Hôtel Dieu de St. Joseph, Edmundston, N.B.

G. MacKinnon, Victoria Public Hospital, Fredericton, N.B.

B. Martin, Miramichi Hospital, Newcastle, N.B.

Mrs. A. E. Melanson, Saint John General Hospital, Saint John, N.B.

Sister Marie Raymond, St. Martha's Hospital, Antigonish, N.S.

Sister Mary of Loretto, Charlottetown Hospital, Charlottetown, P.E.I.

I. Baird, St. John's General Hospital, St. John's, Nfld.

The four weeks of intra-mural sessions were spent under the direction of the registered medical record librarians at the following hospitals:

Royal Columbian, New Westminster, B.C.—Mrs. Ruth Melby

St. Paul's Hospital, Vancouver, B.C.—K. Mann

University of Alberta Hospital, Edmonton—Jessie Naim

St. Boniface Hospital, St. Boniface, Man.—Sister St. Pierre

Winnipeg General, Winnipeg, Man. — Dr. Margaret McGuire

Hotel Dieu, Kingston, Ont. — Sister Keevil

Victoria Hospital, London, Ont.—Margaret McClung

St. Michael's, Toronto, Ont. — Sister St. Cyprian

Hôtel Dieu, Montreal—Sister St. John of the Cenacle

St. Joseph's, Saint John, N.B.—Sister M. Evarista

Halifax Infirmary, Halifax, N.S. — Sister Margaret Clare

Hostels Aid Patients Suffering from Rheumatism

Founded six years ago under the presidency of Lord Nuffield, the British Rheumatic Association has been investigating ways and means to provide up-to-date facilities for treatment, in co-operation with the health authorities, leading specialists, and industrialists. The Association has established that between two and three million people suffer from rheumatism in varying degrees in Britain; and about 500,000 from arthritis, which cripples some 2,000 yearly. It has been established that if sufferers could receive efficient early diagnosis, modern treatment and rehabilitation then, in 60 per cent of cases, they could either be cured or the disease checked.

One of the great problems is that there is not enough accommodation at the few hospitals where there are modern rheumatic units. In order to overcome this difficulty, the British Rheumatic Association plans to open hostels to be run in conjunction with hospitals which have rheumatic units. The first of these hostels is at Bracken Hill House, Northwood, Middlesex, where patients will come under the nearby Mount Vernon Hospital. The hostel is managed by B.R.A. Homes Ltd., in conjunction with the association.

Twenty-five patients can be accommodated at the hostel. It is on two floors, with wards of from one to five beds. Beds not required for early and acute conditions are available to non-bedridden or convalescent patients. Initially, patients are drawn and selected from industry. Industry is supporting the plan and Lord Nuffield has made a two-year financial guarantee of £1,000 a year against loss in operation. — *"Hospital and Health Management", August, 1954.*

Pertinent Questions concerning

Consent for Operations

A. L. Swanson, M.D.

FROM TIME to time, questions regarding consent for operations are referred to the Canadian Hospital Association. Since this matter is of concern to many hospital administrators, some of the questions and answers are given below. In regard to obtaining consent for operations or other procedures, the axiom to follow would appear to be — one cannot be too careful. Therefore, in addition to obtaining information such as that below, it would always be wise for the hospital administrator to discuss legal problems with the hospital attorney.

1. *Is it legal to have a patient sign a consent slip on admission to hospital covering any procedure that might be performed during the hospitalization of the patient?*

There seems to be general agreement among experts that the only valid consent-for-operation form is one which specifically states the nature of the operation and goes on to state that this has been fully and satisfactorily explained to the patient who signs the form, or to the relative or guardian who may sign in the case of minors or others who are not competent to make adequate judgment. The form should be further supported by an attestation clause signed by a witness. Such an attestation clause might be worded as follows: "Read over and explained to the signatory who stated that he/she understood same and affixed his/her signature in my presence. Witness .....".

The general form of consent, which reads to the effect: "I, John Doe, hereby give the ..... Hospital full authority to perform any necessary surgical or operative procedure during the course of my hospitalization and hereby absolve them of any blame", would probably be quite ineffective in a court of law. The plea of the patient bringing suit for damages after signing such a permission form would almost certainly be that he signed it when he was confused and ill and had no true understanding of the nature of the procedure that was to be carried out. Such cases have been upheld in courts of law and the general consent form has not served to protect the hospital or physician. In summary, therefore, it is necessary for every person who undergoes any operative procedure whatever to sign a form which specifically states the name of the operation, that the nature and effects of the operation have been thoroughly explained to the patient, and that necessary local and general anaesthetics may be employed in carrying out the operation. Such a form should be witnessed with an attestation clause as mentioned above. Should subsequent operative procedures be necessary, separate specific forms should be signed by the patient and/or relatives or guardian.

It should be mentioned that the consent for operation form is primarily for the protection of the surgeon who is most commonly the individual who might be held responsible in any case at law. However, the hospital in acting as the agent, by providing equipment, staff, facilities, and so on, is also involved. Therefore, although the consent form primarily protects the surgeon, it is common practice that the hospital should supply properly printed and worded forms and be certain that they are adequately completed. This form protects the hospital from any possible involvement, protects the surgeon, and ensures uniformity of records, which might become very confused if every surgeon used his own consent form.

2. *Is a consent for operation obtained from all patients having an anaesthetic? What about obstetrical cases?*

The answer to the first part of this question would be a definite affirmative. The anaesthetic itself could be potentially dangerous and even though it be of a short duration, *i.e.*, for reduction of a simple fracture, or other type of procedure, there should be a specific operative consent form as indicated above. Consent should also be obtained for obstetrical cases, inasmuch as they usually have some form of local or general anaesthetic at the time of delivery. Some hospitals adopt the practice of having a special "permission for anaesthetic" form, whereby the patient simply gives permission for the administration of a local or general anaesthetic as necessary in the course of a given procedure. Personally, I do not think that this is necessary and believe that the one form can be adapted to all uses. The actual danger in not having properly signed consent forms is that the surgeon or possibly the hospital might be charged with assault. Even a physical examination, done without permission constitutes an assault. However, most cases of physical examination are so routine that consent is implied by the fact that the patient presents himself at the doctor's office or at the hospital, hence a consent form is not

(Concluded on page 134)

Consent by Patient

I, ...

of .....

hereby consent to undergo the operation of .....

the effect and nature of which have been explained to me. I also consent to such further or alternative operative measures as may be found to be necessary during the course of such operation and to the administration of a local or other anaesthetic for the purpose of the same. I understand that an assurance has not been given that the operation will be performed by a particular surgeon.

Dated this day ..... day of ....., 19 .....

Signed .....

Read over and explained to the signatory who stated that he/she understood same and affixed his/her signature in my presence.

Witness .....

At the 56th Annual A.H.A. Convention

Something for Everybody

A RECORD-breaking number of hospital personnel made their way to Chicago, Ill., last Sept. 13th for a three-day whirlwind of meetings and discussions—the annual convention of the American Hospital Association. There were large general sessions, smaller meetings for special groups, a huge exhibit of hospital equipment and supplies, and various social events. Meeting at the same time as the A.H.A. were the American Association of Nurse Anesthetists, American Association of Hospital Consultants, Association of Hospital Planning Agencies, the Hospital Auxiliaries Conference, and the Hospital Industries' Association.

Perhaps it was more than a coincidence that the headquarters city of the American Hospital Association played host to this year's meeting, since the matter of providing a large new building for the association received considerable attention from the House of Delegates. The House was asked for approval of this measure as part of a sweeping expansion program and voted in favour of it. As a means of financing the new ventures, the House also voted to double present membership dues. Approval of the expansion program enables the association to complete arrangements with Northwestern University which is making available a $500,000 lakefront site for the new headquarters building. The site is adjacent to a large medical centre and Northwestern University. The expanded activities of the association will include more research in hospital administrative problems, a furthering of the education program, and greater services to member hospitals. Funds provided by the increased dues will be used to finance the new program and to amortize the new building, according to a schedule which will allow less and less money to go toward the building each year and more and more to be used to finance the program and membership services.

For the Patient

"Improvement of the care of the patient" was the theme of this 56th convention and was developed throughout the general sessions, each one dealing with a particular aspect. Calling for integrated action between governments at all levels and the voluntary health organizations, Senator Lister Hill struck the keynote for the opening session. During the afternoon devoted to the hospital's relationships with the community, Dr. Edmund J. Morrisey of San Francisco pointed out that "in order to serve the best interests of the public . . . it is obligatory on the part of the physician to see that the institution with which he is connected assures the patient of adequate and competent medical care and protection against such unethical practices as unnecessary surgery, fee splitting, and ghost surgery."

Hospital accreditation came in for considerable discussion at the convention. The principles underlying the accreditation program of the Joint Commission were examined in detail, as well as the public service aspects. Dr. Newell W. Philpott of Montreal, P.Q., chairman of the board of commissioners of the Joint Commission, and Dr. Kenneth B. Babcock, Chicago, director, contributed much to these discussions.

An address which evoked considerable interest was that given by Dr. Harry F. Becker, medical director of the Michigan Hospital Service, a Blue Cross Plan. Describing a study undertaken in Michigan, Dr. Becker said that statistics showed "over 28 per cent of all hospital admissions contained some element of faulty use". The Michigan study also showed that Blue Cross members misused their hospital stays in nearly 36 per cent of cases.

Other general sessions dealt with

(Concluded on page 124)

Panel of experts at the annual conference on hospital planning, left to right: Chairman, Dr. Harvey Agnew, of Toronto, president of the American Association of Hospital Consultants; Walter A. Taylor, director, department of education and research, American Institute of Architects, Washington, D.C.; R. Llewelyn Davies, director, division for architectural studies, The Nuffield Foundation, London, Eng.; Dr. Charles K. Bush, director, hospital architectural study project, American Psychiatric Association, Washington, D.C.; Dr. John W. Cronin chief, division of hospital facilities, U.S. Public Health Service, Washington, D.C.; Dr. Anthony J. J. Rourke, hospital consultant, New Rochelle, N.Y.; Dr. Albert W. Snoke, director, Grace-New Haven Hospital, New Haven, Conn.; and O. G. Pratt, executive director, Rhode Island Hospital, Providence R.I.

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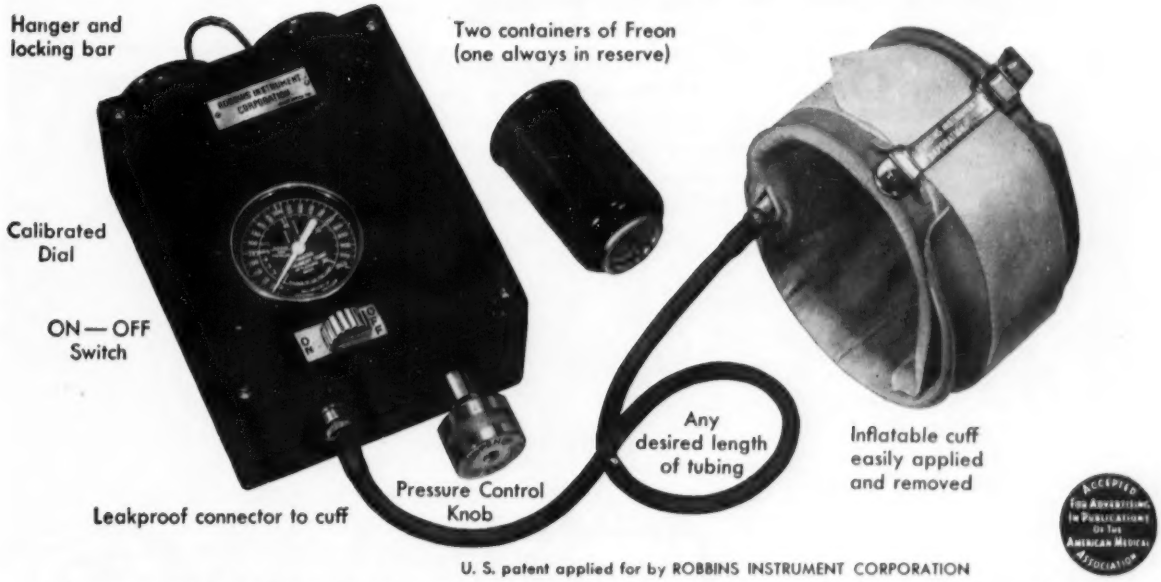

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Research and Nutrition

M. Doreen Smith, Ph.D.,
Professor of Food Chemistry,
University of Toronto,
Toronto, Ont.

TO THE LAYMAN, the term, "good nutrition", means simply good food that will keep him and his family in good health and will provide for the normal growth of his children. To the scientist, the subject is so involved and complex that any relationship between him and the layman seems to be in the category: "if you can't convince him, confuse him".

The first approach to an understanding of human nutrition was, naturally enough, to study the animal organism as a whole. Lavoisier and the other "fathers of nutrition" made studies on respiratory exchange, energy needs, and the factors which influence them. Then, as more became known about the chemical composition of foods ingested, much research was directed towards following, through the body, a single substance or element. Methods have been developed to observe the effects of different enzymes and the mechanisms which have been built up to utilize the substance or element and finally to bring about the breakdown or elimination process. Since the introduction of radio-active isotopes, this second line of attack has advanced rapidly. Still a third line of investigation opened when techniques were developed whereby body organs, tissues, and single cells could be isolated and not only their respiration studied during activity but the influence of various substances on the exchange of gases by the cells or organs could also be measured.

In 1916, the Danish physiologist, Krogh, referred to these "three independent armies of investigators" and at that time he said: "Though there can be no doubt that ultimately the three attacking forces will have to join hands, to support each other, and to utilize in common the progress achieved by each, we find at present they are too far apart for concerted action and the achievements in one field do not materially help the advance in the other". Today it looks as though these three lines are showing a tendency to converge and that some integration of the different channels of research has commenced. Undoubtedly, World War II spurred on this correlation of different findings because of the urgency for over-all good nutrition. Indeed, it is sad, but true, that World War II pointed up more sharply than all our years of teaching the need for over-all good nutrition in man.

Some Recent Experiments

The aim here is to make reference briefly to a few of these studies which were inspired in part by World War II and to attempt to evaluate some of the results since they are good examples of the use made of research findings for the betterment of human nutrition or, in the words of Dr. John Pringle, "attempts to draw from the calamities of war some benefit to mankind". One of these is the great Minnesota experiment by Professor Ansel Keys and his associates on "Human Starvation" which was planned with such wealth of detail and carried out in 1944. It required two great volumes, totalling over 1,300 pages to publish the results in 1950. However, to appreciate the value of this tremendous work, the official report of the Royal Netherlands Government on malnutrition and starvation in Western Netherlands from 1944 to 1945, and published in 1948, should be examined at the same time. You may feel that the discussion of war conditions and their effect on populations is out of date, but the reason for referring to these works is that they each stand out as examples which draw upon all three channels of nutritional research in an attempt to use them in one great quantitative experiment or study. The result of the Minnesota experiment will be used as a standard work for years to come. The late Sir Jack Drummond said of it: "On how many fundamental biochemical processes of the human body does this investigation throw fresh light!"

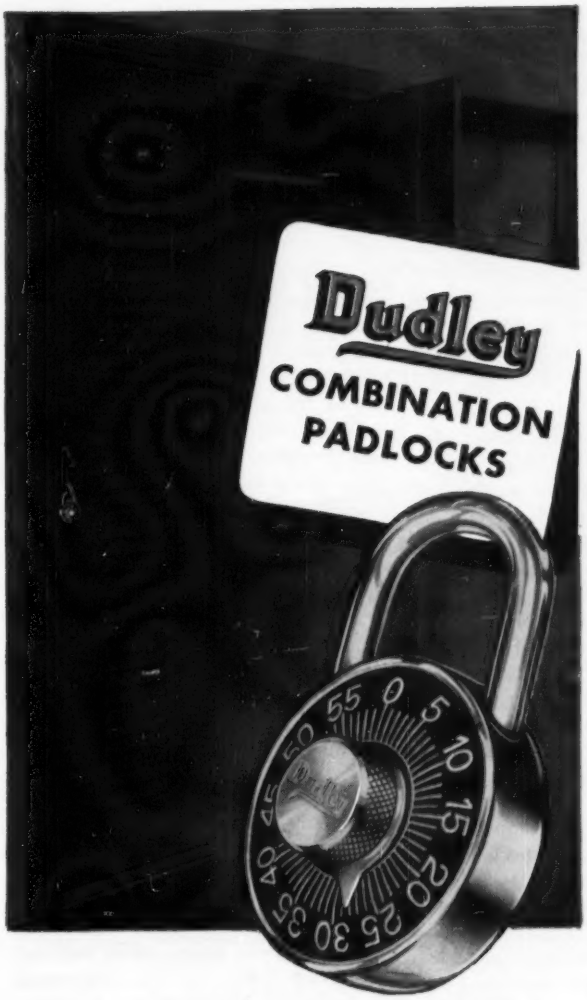
In general, the investigation was planned to study the effects of semi-starvation and subsequent rehabilitation on a sample of the population. Thirty-two healthy men, selected as subjects, completed a six-month semi-starvation period, followed by twelve weeks of rehabilitation. Throughout these carefully controlled periods, clinical, physiological, biochemical, and psychological tests were made. A total of 552 tables was required to record the results.

The Netherlands Report, which is published in two smaller volumes, also deals with conditions of starvation and semi-starvation which were created in the Western Netherlands by the evacuation of the Germans in 1944. Prominent experts from Great Britain, United States, and Canada took part with the Netherlands workers in the relief action. These groups of scientists from the four countries amalgamated their different backgrounds and brought together results from various research findings. Once again studies made from different viewpoints converged to focus on the human body as a whole. While the action was taken as an emergency measure, it was so organized that as much scientific data and as many good records were obtained as was humanly possible. In the Netherlands about 10,000 deaths were believed to have occurred through starvation during the period when the Germans knew that they would have to leave before the Allies took over.

It was unfortunate that the Minnesota experiment could not have been undertaken and completed sooner in order that the results could have been used in the Netherlands. The scienti-

(Continued on page 72)

An address presented at the Canadian Home Economics Association Convention, Toronto, August, 1954.



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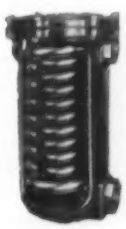

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(Continued from page 70)

fic teams planning the relief measures found that they had very little precise information on how to treat properly those suffering from prolonged and grave starvation. They made certain assumptions, namely that vitamin supplements and predigested foods, especially protein hydrolysates would be extremly valuable in the treatment of these starving individuals.

However, subsequent study of the population showed that even though there was great undernourishment there was little evidence of nutritional deficiency diseases. There was famine oedema; and the analyses made on the blood serum or plasma by the teams of workers showed some deficiency of vitamin A and niacin. Two reasons are suggested for the lack of vitamin or mineral deficiency diseases. First, the shortage of food supplies led to the consumption of whole grain cereal and of large quantities of any vegetable foods that could be obtained, even tulip bulbs were said to be consumed. Secondly, because the energy intake was so markedly cut down, the requirements of the body for certain vitamins would be reduced. In the Minnesota experiment, the expected evidences of vitamin deficiencies were not found either. In both these studies, it should be noted that the starvation periods were relatively short.

Considerable emphasis is placed on the basal metabolic rate studies in the Minnesota experiment. F. G. Benedict, in his standard experiments, had noticed a decrease in the basal metabolic rate in starved subjects. After World War I a decrease in the basal rate was observed in the undernourished victims. In most cases, it was found to be more than could be accounted for by the reduced weight of the subjects but it remained questionable if this was an actual physiological adaptation to reduced caloric intake. If the body can adapt itself to this condition by decreasing the rate of energy exchange internally it would have an important over-all significance.

The results of the Minnesota experiment do establish this idea that the "active tissue" of the human body does have the capacity for adaptation to a lowered caloric intake by decreasing the total basal metabolic rate. This enables man to survive longer on a semi-starvation diet than he would if his basal metabolic rate remained normal. At the end of the experiment the rate was reduced by almost 40 per cent over the control period. This saved the body approximately 500 calories per day. In the Netherlands Report, they also found basal metabolic rates had fallen more than could be accounted for by loss in weight. This lowered basal metabolic rate would be involved in the vitamin-sparing action. The body temperature of the subjects in the Minnesota experiment and in the Netherlands averaged about two degrees Centrigrade below the normal and in all cases subjects complained about feeling cold.

In connection with the Netherlands Report, the second assumption that pre-digested foods would be required proved to be unwarranted. It required a great deal of high pressure on suppliers and a tremendous outlay of money to prepare and fly in protein hydrolysates; but it was felt to be justified if thousands of lives could be saved. From both these starvation studies, evidence showed the gastro-intestinal tracts were not impaired and that the individuals digested skimmed milk and even butter exceedingly well. The giving of the hydrolysed milk casein proved to be a disappointment in the feeding of the subjects in the Netherlands. The acid hydrolysate fed intravenously produced venous thrombosis and the enzymic digest of casein fed orally does not taste pleasant, thus sometimes nauseating the patient. Both studies emphasize that a high caloric, adequate protein diet is indicated and that the rehabilitation period is much longer if the high calories are not given almost from the beginning. Also in both studies it was learned that the psychological state of the patient made it necessary that the subjects be approached with understanding. It might be suggested here that the value of hydrolysates in the Netherlands would have been in using them to mix with high caloric drinks, potatoes, and in any other food in which they could be disguised, in order to help increase the protein content of the diet rather than in feeding them unmixed with other foods.

Both of these great works demonstrate that there is still a great deal to be learned about the general over-all nutrition of the human body during normal, fasting, and recovery periods. This is especially true of the inter-relationship of protein, vitamins, and calories in malnutrition and in the convalescent period. On the other hand, both of these studies are magnificant contributions to the future—the Minnesota experiment because of the number and variety of tests and controls and the Netherlands operation because so many tests were carried out and even a certain number of controls planned, under emergency conditions.

Nutrition Surveys

Another type of over-all human nutrition study that differs again from the planned experiment or the studies made under emergency conditions is the nutrition survey in an area where deficiencies are indicated. In Canada, our thoughts turn to Newfoundland since it was here during the war years that the need was felt to examine the nutritional status of the population and do something about it. From 1912 on, occasional reports had been made noting various deficiency diseases among the people living in Newfoundland; but it was not until 1944 that several quite comprehensive surveys were undertaken. One of these, which was conducted at the invitation of the Commissioner of Public Health and Welfare, is the one we hear of most since four Canadians (the late Dr. F. F. Tisdall was one of these) as well as British and American medical men, carried out the original survey in 1944 and the re-survey in 1948. Another survey by an all-American group, which included Dr. Grace Goldsmith, was commenced a month earlier than the Canadian survey. The American group also carried out a re-survey four years later. The first survey of the Goldsmith group was made just prior to the enrichment of flour by thiamine, riboflavin, niacin, and iron; and the Tisdall *et al* survey was made just after the enrichment of flour and the addition of vitamins A and D to margarine but before these foods came into general use. Six months after the Tisdall survey, a third survey was made by a British scientist, Dr. D. P. Cuthbertson, now director of the Rowett Research Institute, Aberdeen. His work is not so well known here in America. He criticized some of the statements of the Tisdall report, especially the findings respecting a high prevalence of vitamin A deficiency among the whole sample of the population. In discussing the Tisdall and Goldsmith surveys which preceded his, Dr. Cuthbertson said: "On the

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Research and Nutrition

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whole . . . the tendency was to read too much into symptoms in an effort to trace the earliest manifestations of deficiency diseases". He compared his own survey with that of the other two; and in his observations he "did not discern such widespread evidence of abnormality as was noted in the other two". However, all of the investigators concluded in general that there was need for definite measures to be carried out to improve the quality of the diet. The advice respecting nutritional education and improvement of agricultural policy (home grown vegetables, et cetera) which was given to the government was excellent.

There was a difference of opinion respecting enrichment of flour. I mention this because it is another example of how various research workers and clinicians had to draw from large numbers of studies to put together a plan best suited to the conditions. Dr. B. S. Platt, the British investigator on the Tisdall 1944 survey, looked upon the introduction of this flour as satisfactory only for a short-term measure. He advised that serious consideration should be given to the manufacture of food yeast from sulphate wood pulp liquor waste and the use of this as an additive to flour to take care of the whole vitamin B complex.

There is no doubt that the therapeutic value of certain vitamin and mineral supplements has been established where some one very clear-cut deficiency disease exists. None of the surveys made in Newfoundland reported incidence of beriberi, pellagra, zerophthalmia, rickets, scurvy or anaemia. However, the records showed evidence of deficiencies or suggested signs of deficiencies with respect to the various vitamins. However, there is some variation in the results reported—for example, the Tisdall survey records that three per cent of those examined showed apparent signs of rickets, the Goldsmith survey, nine per cent and the Cuthbertson survey 0.3 per cent. This same type of discrepancy exists in the other signs of deficiency reported except in the case of dental caries in which there was 100 per cent agreement as to actual figures and as to its being widespread. Nevertheless, there was no doubt in the minds of any of those making the surveys that a general condition of malnutrition was present in a large proportion of the population. Possibly many were borderline deficiency cases with respect to more than one nutrient.

The results of the Minnesota experiment show that the use of vitamin supplements had no effect on the course of rehabilitation in the severely undernourished, nor is there any objective evidence of their value in the trials in Europe following the war. In the Cuthbertson report on Newfoundland, it is advised that wherever possible the balance of essential nutritients in the diet should be brought about by using a variety of natural foods. Cuthbertson objects strongly to the use of synthetic vitamins and his opinion in 1947 was that after two years trial of the enriched floor it should have been replaced by 78 to 80 per cent extraction floor. He believed the excellent health found in Britain on this flour warranted his view. He suggested calcium, iron, and food yeast or, if that were not available, riboflavin might be added. The only part of his advice on which action was taken was the addition of calcium in the form of bonemeal, in 1947, to enriched flour.

Results of Re-Surveys

It is of interest now to examine some of the results of the re-surveys made in 1948. The Tisdall group reported that "the prevalence of lesions which may be related to deficiencies of vitamin A and of thiamine, riboflavin, and niacin was strikingly diminished". The Goldsmith group said "considerable improvement had occurred in the general nutritive state since 1944". They observed a "striking decrease in the incidence of several signs and symptoms related to vitamin B complex deficiency" but noted few changes relative to vitamin A. They comment that their report differs from that of Tisdall *et al* in that the prevalence of some clinical signs which may be related to vitamin A or to riboflavin deficiency was not diminished in 1948. Margarine had been fortified with vitamin A for four years. Does their observation mean that the symptoms they were attributing to vitamin A deficiency are caused by some other factor, or does it mean the increase of some other vitamin or nutrient in the diet has stepped up the need for vitamin A? The answer to this is still unknown.

Finally, there is one point on which both re-surveys agree, *i.e.*, that the picture with respect to dental caries and gum conditions had not improved. The Tisdall report which had figures for the serum level of ascorbic acid in 1944 and again in 1948 showed a fall in the ascorbic acid level on the average of approximately 12 per cent in the 1948 analysis. There was also an increase in the prevalence of reddened and swollen gums which is thought to be caused by lack of vitamin C. Import duties on fresh fruit had been removed, concentrated orange juice was distributed free to expectant and nursing mothers and to infants under one year of age. The economic position of the country had improved so that one would not have expected the actual intake of vitamin C to have decreased. No measurements were made of the amount of vitamin C ingested.

Several investigators have suggested a relationship between vitamins C and A. Is it possible that increasing vitamin A requires a corresponding increase of vitamin C? The function of vitamin C is not too well known. It is thought to be connected with cell oxidation. Riboflavin is also connected with the respiratory system. It may be that if all the factors in body functioning are at a low level one or two should not be increased out of proportion to the others. Indeed as the studies on individual vitamins, enzymes, amino acids, fatty acids, et cetera, are developed we find out more and more about the inter-relationships which exist between one and another of these dietary nutrients. In other words, not only are relationships being discovered between one or another vitamin, but between vitamins and other nutrients.

Since some sections of Newfoundland are only accessible by boat, it is to be regretted that one of these isolated sections had not been put on a high extraction flour in order that comparison might have been made with this population and those fed on the flour enriched by three only of the B vitamins and iron. In an area where there is a general low level of nutrition, one wonders about the wisdom of stepping up a few nutrients to a very high level, rather than aiming at an over-all improvement of the diet as a whole.

It was mentioned earlier that the dietary advice of those making the surveys was excellent. The five surveys, to which reference has been made, all point out the need for better

(Concluded on page 132)

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Allocation of Duties in a Medical Record Department

Anne Murphy,
Medical Record Librarian,
North Vancouver General Hospital,
Vancouver, B.C.

THE MEDICAL record department in a hospital of 125 beds may carry out various procedures, such as typing miscellaneous reports, distribution of supplies, et cetera, for which specific departments are responsible in larger hospitals. The allocation of these duties, of course, dependent on the number of personnel employed in the department and their qualifications. We have endeavoured to work out an uncomplicated system for our staff in the medical record department and, for the past year, have found the daily routine, outlined here, has helped us to obtain complete medical records and to provide statistics and other information required by our hospital administration and medical staff.

Personnel and Responsibilities

The personnel in our medical record department consists of one medical record librarian, a medical stenographer, and one clerk-typist. Their responsibilities are as follows:

Medical Record Librarian

1. Organization and management of the department under the supervision of the director of medical records, who is chairman of the medical record committee.
2. Instruction of personnel in regard to policies and procedures.
3. Compilation of daily statistics, special statistics, monthly reports, and annual reports.
4. Preparation of statistics for tissue committee.
5. Contact doctors to complete records.
6. Code diseases and operations according to Standard Nomenclature.
7. Telephone.

Medical Stenographer

1. Assistant to medical record librarian.
2. Discharges.
3. Check medical records.
4. Assemble cross-index slips for typing; and maintain files of index of diseases and index of operations.
5. Transcribe consultation reports, operation reports, and notes covering ward rounds, which have been dictated.
6. Correspondence.

Clerk-Typist

1. Daily empty-bed report for provincial hospital insurance service.
2. Daily census report for administrator.
3. When charts of discharged patients are received, assemble each record in proper chronological order and pass these records to medical stenographer for checking.
4. Admissions.
5. In-patient file.
6. Master file—patients' alphabetical index.
7. Permanent file—when record is complete.
8. File with patient's record reports which are delivered to medical record department after patient's discharge.
9. Provincial hospital insurance service forms. Other insurance forms are not handled by our department but are referred to the general office.
10. Type copies of reports required by the Workmen's Compensation Board.
11. Make up basic charts and distribute them to the nursing stations daily.
12. Type electrocardiogram reports.
13. Collect "requisition for supplies" slips from nursing stations every Thursday and deliver the required forms, such as graphic sheets, nurses' notes, et cetera, the following day.

The number of discharges varies from 15 to 30 per day. Out-patients or short-stay cases are private patients and the "Short-stay or Emergency" form is numbered and filed by general office personnel. If a patient is admitted, the short-stay or emergency form becomes part of his medical record and is filed with his chart in the medical record department.

Our department carries out its various procedures in the following manner.

Processing Medical Records

1. Charts of discharged patients are sent to the medical record department the morning following discharge.
2. Assemble each chart in proper chronological order.
3. Compile discharge list from information on charts.
4. Check charts for errors or omissions and refer to attending doctor for completion.
5. Compute daily statistics from charts received, according to service, result, patient days' stay, and note operations and consultations.
6. Record statistics for tissue committee (re agreement of pre-operative, post-operative, and pathology report diagnoses; normal tissue removed; no tissue removed; specimen not sent to laboratory).
7. Record in ledger special statistics such as: Deaths; Paediatrics—in our hospital these are broken down into medical, surgical, urological, orthopaedic, and E.E.N.T. groups; Ceasarean sections—reasons for; Prematures, non-survivors, cause of death; Newborn—congenital defects; Stillborn; Hospital infections; Post-operative deaths.
8. Complete provincial hospital insurance service forms.
9. Place incomplete records in cubicles for attending doctor.
10. Set aside complete records for coding and indexing.
11. Code diseases and operations according to Standard Nomenclature. Use a separate slip for each diagnosis. These slips are later assembled in numerical order and information typed on cross-index cards.
12. When all above procedures are completed and all missing reports, errors and omissions attended to, charts are ready for permanent file.

Admissions

1. Obtain admission sheets from general office in the morning.
2. Note compensation cases, so that extra copies of consultation and operation reports may be made for Workmens' Compensation Board.
3. Enter admissions in admitting ledger.
4. Check master file cards for pre-

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Balance between Tradition and Economy

A. Whiteman,
London, England

CRITICISM has been levelled recently at nurses' uniforms worn in many English hospitals on the grounds that their elaborateness adds greatly to the cost of laundry finishing. Tradition has been responsible for the retaining of present uniform styles — for such things as starched cuffs and collars have no apparent practical purpose.

In spite of the obvious economical advantages of standardized uniforms, it is felt by most hospital authorities that tradition cannot be overlooked. It plays its part in recruiting nurses and maintaining morale and discipline.

A valuable contribution towards a solution of this problem has been made by Newcastle Regional Hospital Board. A sub-committee appointed by the board to inquire into laundry costs studied very closely this question of nursing uniforms and decided that they added considerably to the costs of laundry services. The board therefore undertook a study of nursing uniforms and tried to obtain a uniform which would be economical and yet attractive. A competition was held in which various grades of nurses were asked to submit uniform designs. The board has now issued a report embodying the findings of that study and giving the results of the competition.

If, states the report, simplified nursing designs were adopted, spread over 100,000 nurses this could result in an economy of £190,000 ($532,000) a year. No one uniform is recommended as ideal but investigations have shown that certain principles can be followed which will result in economy.

The first problem was to define clearly the necessity for uniforms as such, which was: so that patients and visitors would know the wearer was a nurse; because uniforms can readily be kept hygienic to the benefit of both patient and nurse and present a simple method of denoting service and rank; are the accepted dress of any service and, if attractive, are an aid to recruitment.

The competition invited uniform designs for nursing sisters, staff nurses, student nurses, state enrolled assistant nurses, pupil assistant nurses and male nursing staff. Entries in each class were restricted to members of that class. Twenty-seven entries were submitted and nine were made up to be judged in a parade.

An example of the suggested uniforms may be seen from a description of the prize-winning design in the staff nurses section. This was in white nylon, having a plain bodice, with darts back and front, and two pockets. The skirt had seven gores which, it was submitted, could be increased or decreased to fit any figure without altering style. The sleeves were short with turned back cuffs. The dress buttoned throughout which, with detachable buttons, would lead to ease of laundering. The apron had a square bib with no straps and a three-gored skirt. The cap was "American style" with a seniority band on outer edge of turnover. It was submitted that this uniform was suitable for all grades of nurses with alteration of epaulettes and cap band.

After the competition, uniforms were submitted to practical washing tests. A medium-sized hospital laundry was used. Examination of uniforms was made after ten washes and again after 20 washes.

There was excessive shrinkage with two entries and some with another. Excessive wear showed in the seersucker materials used in two others. It had been claimed by one competitor that nylon and seersucker materials would not need ironing, but this was not borne out by the tests.

The main reasons against recommending the use of nylon in uniforms were, states the board, that it was much more expensive than cotton material and was a generator of static electricity, being therefore, a danger in operating theatres or any places where inflammable gases were present. It was felt however, that nylon could be used in accessories such as collars, cuffs and caps where they would add to the appearance of the uniform, provided they were not used in operating theatres.

Alternative materials were examined and it was decided that the most suitable material was a cotton regatta, obtainable in a soft finish.

"Garments of a simple design," the report goes on, "can be the most attractive. Simplicity of design leads to economy of laundering. The cost of laundering, like any other service, depends upon the amount of time taken by the process. Hand-ironing or machine-pressing consists of evaporating the moisture in the garment and smoothing it at the same time. Whenever extra thickness of material occurs, the evaporation time is longer. It therefore follows that pleats should be avoided, and enough designs have been seen with gored or button-through skirts to show that an attractive uniform can be made on these lines. Wrap-over skirts also are easily pressed, but a greater amount of material is required for these."

On the question of caps the report states that the laundering cost can be high for those of elaborate design. It recommends therefore that where

(Concluded on page 94)

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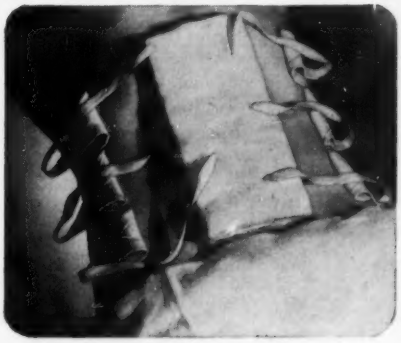

Fig. 1

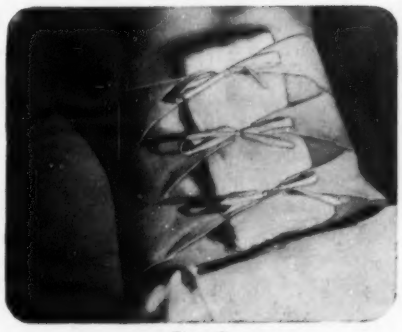

Fig. 2

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Six pieces, each about 12 inches in length, are prepared from a 3-inch wide Elastoplast bandage. Tapes are attached and the completed pieces applied to the body from each side (Fig. 1). The tapes are tied over the dressing covering the wound (Fig. 2). The bandage may be applied by one person without disturbing the patient. It is easily made, provides adequate support and will remain firmly in position.

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Provincial Notes

British Columbia

VANCOUVER. Renovations to the Heather annex of the Vancouver General Hospital are under way. The provincial government has agreed to pay one-third of the cost of the $50,000 project, with the city paying the balance. At peak capacity the annex has accommodation for 100 persons and is used to hospitalize indigent old age pensioners.

* * * *

WHITE ROCK. The Hon. Eric Martin, provincial minister of health, opened the new $430,000 White Rock Cottage Hospital recently. Construction work on the new 45-bed building began in November, 1952. The provincial government contributed $236,000 towards the cost of construction, the federal government $50,000, and the remainder was contributed by the community.

Alberta

VERMILION. The contract has been let for the construction of the $257,000 addition to the Vermilion Municipal Hospital. Expansion plans call for the conversion of the original hospital quarters into a nurses' home. The addition, plus the wing built in 1940, will bring the hospital's capacity to 54.

Saskatchewan

HERBERT. The Herbert Invalid Home, a 24-bed home for the aged and infirm, was opened recently. Sponsored by the Saskatchewan Mennonite Youth Society, the $17,000 home was financed by the Mennonite Society, charitable donations, and a $3,400 grant from the provincial government. The two-storey, H-shaped building is of frame construction with asbestos siding and asphalt shingles. Accommodation for the ambulant and bedridden residents of the home is provided in single, two-bed, and three-bed rooms. Rates at the home are $40 per month and it is open to all religious denominations. It is expected that an additional 48-bed wing will be added within the next five years.

* * * *

MELFORT. In August, Premier T. C. Douglas of Saskatchewan officially opened the new 150-bed nursing home here, which will be used for the care of the aged and infirm. Situated on a large block of land to allow for future expansion, the one-storey building was constructed by the provincial government, at a cost of $1,000,000. The residence charge is $40 per month per individual and residents from anywhere in Saskatchewan will be admitted as long as accommodation is available.

* * * *

MOOSE JAW. The Hon. T. J. Bentley, provincial minister of public health, laid the cornerstone of the new Memorial wing of the Moose Jaw Union Hospital, in August. The new wing has six-storeys and a basement.

Manitoba

ST. BONIFACE. A new wing to the St. Boniface Hospital School of Nursing was opened in August. Four floors of the five-floor building are given over to bedrooms for student nurses. The bedrooms are single and there are 21 rooms on each of the four floors. Features of the classrooms, which seat 100 students, include indirect lighting and air-conditioning. The wing also has a demonstration room, library, science and nutrition laboratories, and recreational facilities. Each floor has a dust chute connected with the incinerator in the basement and a linen chute connected with the laundry.

* * * *

WINNIPEG. Construction work has begun on the new 300-bed extension and new nurses' home at the Misericordia General Hospital. Estimated to cost approximately $3,000,000, the buildings will probably be completed by December, 1956.

Ontario

BELLEVILLE. The board of governors of the Belleville General Hospital have announced that tenders have been called for the construction of a new $1,250,000 wing. Architects for the new building are Govan, Ferguson, Lindsay, Kaminker, Langley, and Keenleyside of Toronto.

* * * *

CHAPLEAU. Government approval has been secured for the construction of a new $130,000 nurses' residence to accommodate the staff at the Lady Minto Hospital. The new residence will increase the hospital's bed capacity from 28 to 42 through the release of rooms now occupied by staff members. Construction work is to begin shortly on the one-storey building. It will contain accommodation for 14 nurses, as well as an apartment with kitchen and lounge for the hospital's superintendent. A recent donation of $20,000 from the W. E. Mason Foundation in Sudbury will be used to install an elevator in the hospital.

* * * *

NIAGARA FALLS. The Greater Niagara General Hospital's public campaign for funds has now gone over its $600,000 objective by $370,000.

* * * *

PALMERSTON. The new wing of the Palmerston General Hospital, which has been built at an estimated cost of $130,000, will be ready for occupancy shortly. The hospital has a bed capacity of 44, with 12 bassinets. Included in the basement is the morgue, laboratory, dining room, kitchen, x-ray, and examination room. On the main floor will be offices and general wards; while the obstetrical department will be on the top floor.

* * * *

STRATFORD. The board of directors of the Stratford General Hospital Corporation has inaugurated a pension plan for retiring hospital employees. The plan, which was made effective as

(Concluded on page 122)

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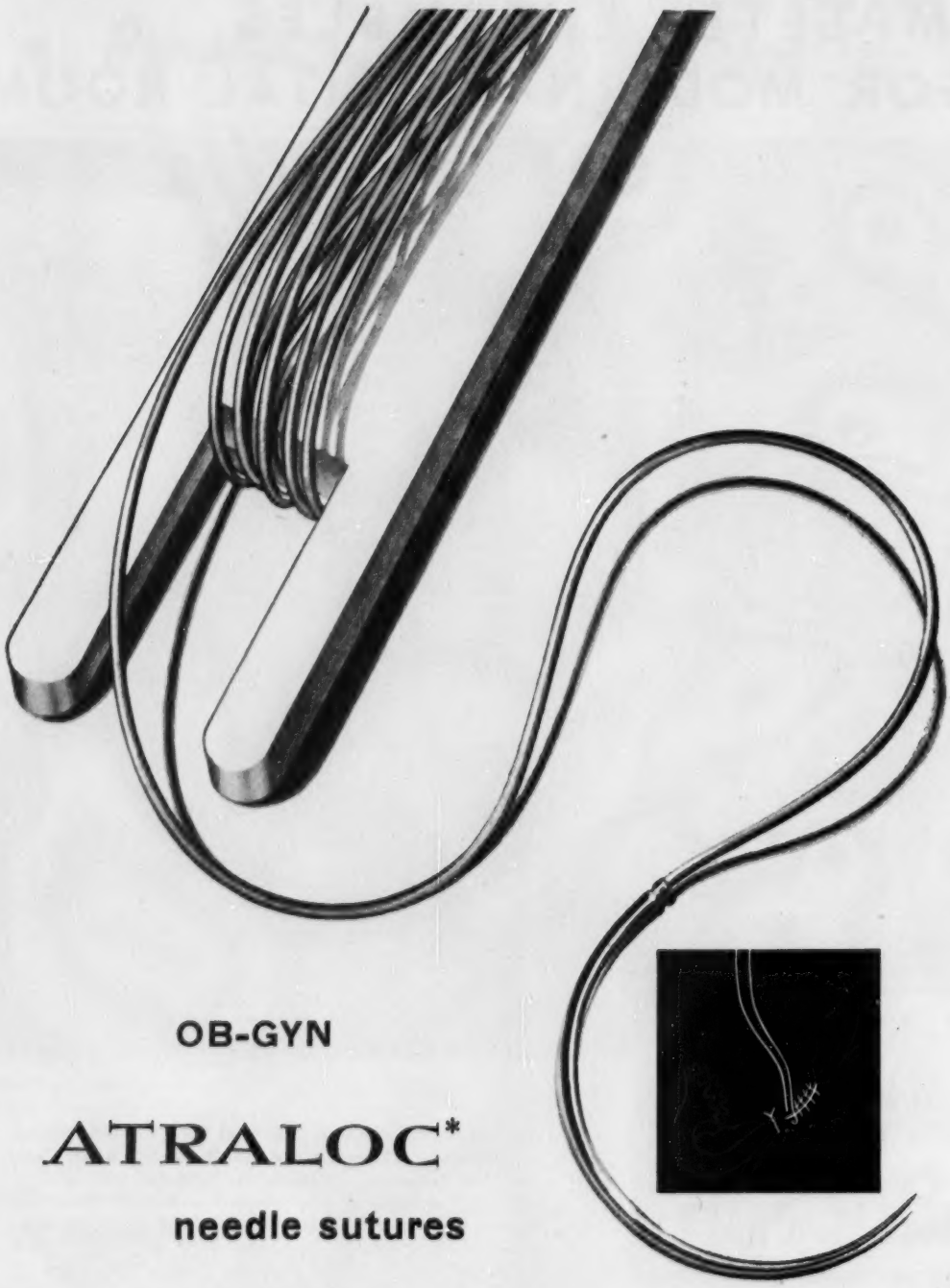

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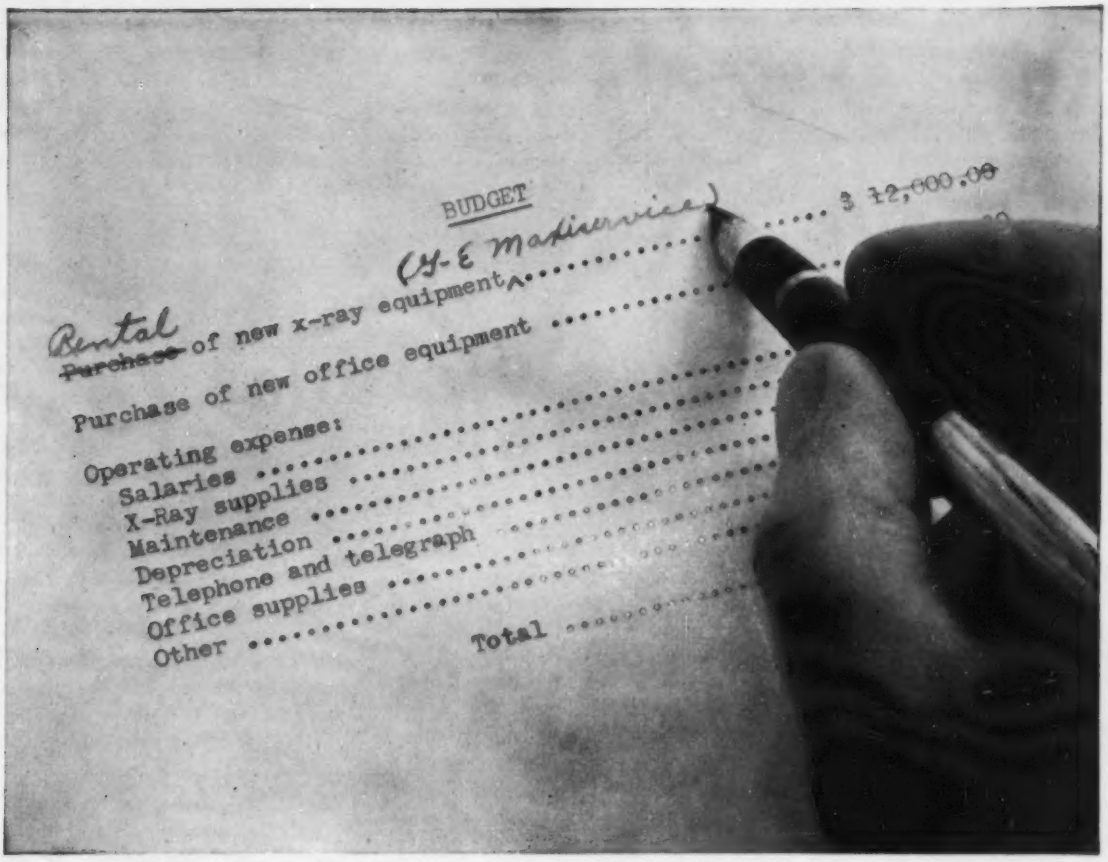

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What of the Night?

(Concluded from page 49)

order to fit a specific program of night coverage into the over-all picture of the hospital.

What Does "On Call" Imply?

Before leaving this facet of night coverage, namely "on-call" coverage, it is pertinent to review a few of the broader implications and concepts of "on-call" duty.

The very term "on-call" implies the availability of an individual who has given eight full hours of duty to the service before being placed "on-call". Such a person is not at all receptive to being rooted away from home or having what should be his own free time disturbed and disrupted in order to report into the hospital. The first thought he has, and justifiably so, is increased compensation for this irritating and demanding routine. There are several aspects of salary compensation that could be invoked and a brief consideration of the theory of compensation will be of value.

Pay for Overtime

If the individual is a member of a unionized department, there will be little choice of action. He must be paid over-time wages at the current rate and percentage for over-time as has been established through union bargaining.

Non-unionized individuals, and this includes the great majority of hospital employees, may be compensated by an over-time wage scale as established through personnel policies, by compensating relief time, by having transportation provided and meals if necessary, or by combinations of the foregoing.

Generally speaking, employees find call-back duty to be extremely undesirable and hospitals often find themselves unable to provide such coverage on a volunteer basis. Theoretically, it would seem that when an employee is on call he has, in a sense, been placed on limited duty. He cannot proceed with the normal activities he would ordinarily be involved with, his actions are restricted, and he must at all times remain accessible for this "on-call" period.

Many hospitals will find that because of the shortage in personnel it is virtually impossible to provide compensatory time off in lieu of monetary compensation even though this time may be added to bring about an increased vacation period. Even larger institutions are faced with this problem and, in general, it is easier to procure a full-time night employee than it is to provide an "on-call" employee with a suitable compensation.

It follows, in theory, that a just compensation should be developed. When an employee is hired he should be informed of any on-call and call-back demands that may be part of the job. A just form of compensation, arrived at in an individual case or a set of personnel policies, should be developed to cover these problems.

The most logical plan is to compensate for "on-call" and call-back duty by a reduced compensation based on a weekly salary or hourly wage. This compensating figure should be based on an average percentage of actual duty hours (over-time) and "on-call" hours and a basic minimum figure arrived at which would be added to the employee's weekly salary. Call-back time over and above this average should be taken into consideration, in addition to the minimum wage.

Let us examine a hypothetical situation: Employee "A" is a maintenance engineer at a salary of $2.00 per hour. Personnel policies state that since he is "on-call" and if he is called back to duty no more than ten hours per week he will receive $25.00 in addition to his weekly salary. If his call-back time exceeds ten hours he will be paid at his prevailing rate for the duty hours exceeding ten hours.

Advantages of Compensatory Pay

The advantages derived from such a scheme of compensatory pay for "on-call" and call-back duty are several:

1. The employee is satisfied. He has a minimum guarantee for restricted hours and actual call-back time with provision for more equitable compensation.

2. If the minimum has been established statistically and properly, it should seldom be exceeded. As a result, timekeeping and payroll efforts are also minimized.

3. The management will have much less difficulty in maintaining an adequate force of personnel willing to take an "on-call" status.

4. It is more economical than hiring a full-time employee in most cases. Where the minimum would be exceeded consistently, it obviously requires investigation to determine if a full-time employee is required.

In the United States Department of Labor *Bulletin on Collective Bargaining Provisions*, we read that it is common in union agreements to guarantee a minimum payment to employees who are called back to work.

Union agreements and contracts generally include a provision which provides for such contingencies as being called back to duty, by requiring a minimum call-back pay. These agreements usually specify a minimum guarantee to cover those situations where little or no actual work develops after such a recall, as well as wages to be paid for hours in excess of the guaranteed minimum. Of course modifications of this principle exist which provide for combinations of these two major provisions.

Some contracts specify different hourly monetary rates for emergency, call-back, on-call, transportation, waiting time. All of these are met by the hospitals, although not as realistically as by industry as a whole.

(To be continued)

The Search for Food

Food is a primary need of man and one of his ever-present problems. From the days when the Neanderthaler stalked his prey in the primaeval forests to the modern deliberations of the Food and Agricultural Organization of the United Nations, food has posed major problems.

But nutrition is essentially a problem of civilization. Our savage ancestors learned what to eat by trial and error. Food was scarce and the search for it was never out of mind. Later, as nomadic tribes settled down, sowed their crops, and tended their herds, assurance of a more stable food supply increased the general feeling of security.

Gradually, the search became less of a necessity and attention to the taste and variety of foods grew in importance. Then, improved transport and machine processing resulted in many agreeable foods which were pleasing and so were eaten in large amounts. This introduced a new era. Civilized men began to use a diet which was markedly different from that of the natural state and which lacked many of the important elements on which the human body depends for growth. Thus, many deficiency diseases made their appearance. — *From "C-I-L Oval", Aug., 1954.*

ALL WINDOWS IN THE

Nora Frances Henderson

HOSPITAL

HAMILTON, ONTARIO

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Alternating casement and vertically-pivoted windows continue around the entire perimeter of this modern hospital, and blend with its general motif. Engineering research into the latest medical and architectural needs assures adequate light and controlled ventilation through windows alone. Alternating vertically pivoted units and casements, on single-thrust ball-races, facilitate cleaning, and casements may be opened without removing screens. CRITTALL can meet *all* hospital and sanitorium requirements—and invite your enquiries.

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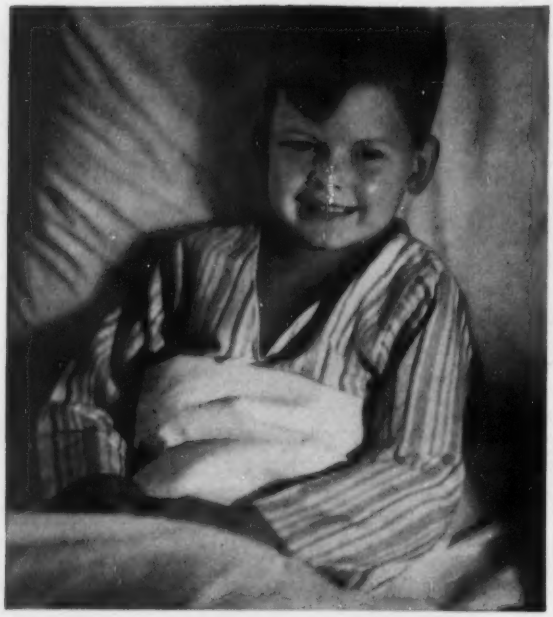
Why a thermostat in every room is a

MARK OF A MODERN HOSPITAL



76° **In room 508,** this active youngster is recovering from minor surgery. Because this hospital has Individual Room Temperature Control, the temperature in this room can be set at 76°—assuring a proper room environment even if he hops out of bed or kicks off his blankets.

70° **In room 608,** this patient's physician feels 70° will help speed her recovery. With a Honeywell Hospital Thermostat in each room, physicians can make room temperatures part of their prescription.

Physicians in modern hospitals that have Individual Room Temperature Control can prescribe the *exact* room temperature needed to speed each patient's recovery. This medical practice can be followed *only* if the hospital has a thermostat in every room—for no other method can compensate for the varying effects of wind, sun, open windows and other variations of internal load in each room.

That's why Individual Room Temperature Control should be an important consideration if you plan to build or modernize your hospital. Of course, the most economical time to install this modern system is when the hospital is being built. For, contrary to most beliefs, Individual Room Temperature Control is not expensive — most installations will cost only between ½ and 1% of the expenditure per bed.

For complete facts on Honeywell Controls for your hospital, call your local Honeywell Office—there are 14 in key cities throughout the nation. Or for literature, write Honeywell, Dept. CH10, Leaside, Toronto 17.

First thermostat specially designed for hospitals!

You get *all* these features only on a Honeywell Hospital Thermostat:

- *"Nite-Glowing dials"* permit inspection without disturbing patients.
- *Magnified numerals* make readings easy to see.
- *New Speed-Set control knob* is camouflaged against tampering.
- *Air-operated;* requires no special connections.
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We maintain our own manufacturing plant where skilled operators are ready to make up curtains to your specifications.

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Labour Problems

(Concluded from page 36)

5. *Industry* uses assembly line methods of production.

Hospitals must use personalized methods of service.

6. *Industry* trains employees for its own specialized program of activity.

Hospitals train doctors, nurses, technicians, et cetera, for public health services, industry and community needs of all kinds.

These comparisons will make us realize that hospital administration faces a three-fold problem in its personnel relations program not generally experienced by industry:

(a) The necessity for providing a service which suffers no interruption;

(b) The difficulties of controlling revenue and expenditure;

(c) Particular problems of supervision and training to obtain an ever-increasing level of efficiency in hospitals.

Let us briefly discuss these three prongs which constitute a hospital's special labour problem.

Service without Interruption

While this statement appears on the surface quite evident, few people realize all of its implications. A few years ago when hospital costs began to rise, the question was often asked why a private room in a hospital might cost $15.00 a day, while a very comfortable room in a hotel could be obtained for perhaps $6.00 to $10.00 a day. People making such statements failed to recognize that in a hospital, service is available 24 hours a day, and that over and above hotel service, there is the wide range of hospital service to be supplied by professional people.

Hospitals as we have said earlier, must stand ready to give emergency service at all times. In fact as our country becomes more industrialized, and as a greater number of people use planes, railroads, cars, more accident cases are being admitted to hospitals at irregular hours and at times when the ordinary industrial plants are closed. To provide service seven days a week, 24 hours a day is no small task in this age of daylight saving time, long week-ends and shorter working days.

Difficulties of Controlling Revenues and Expenditures

It is a well known fact that hospitals do not operate at a profit. I understand that it is usually sound business practice to maintain a reserve equivalent of at least 10 per cent of the operating budget for contingencies. Yet hospitals have no reserve. They continuously deplete their capital for current operations and when the time comes to replace obsolete or depreciated buildings and equipment they must resort to extraordinary means of financing such as fund-raising campaigns and loans. In 1950, when our hospital was completely evacuated for three weeks because of the flood, the deficit rose to an alarming figure; yet there was no provision made to take care of it. Hence certain programs for improvement of facilities and equipment had to be further delayed. Under such a regime there comes a time when the very existence of an institution may be jeopardized. Why should hospitals have to operate at a deficit? Is it because of the nature of their services which must be made available to all regardless of financial ability to pay?

As far as expenditures are concerned, no service no matter how costly can be spared if a patient's life is in danger. Very expensive equipment designed today, obsolete tomorrow, must be made available if with it only once, a man's eye, arm or foot will be saved.

Supervision and Training

There is indeed a particular problem of supervision in hospitals. Working within one department we find all types of workers: professional, non-professional, skilled, and unskilled. It would seem that in hospitals, as a matter of tradition, emphasis has been on training in the healing arts and training for a technical profession, not on training for supervision. Hence, the conflict between the wish to perform work and the duty to supervise employees can be strong and can result in unnecessary tension and fatigue among supervisors. I can see the day approaching when instead of adding employees with the hope of increasing efficiency, we will add to the supervisory level by having functional organization replace regional organization to relieve department supervisors. Housekeeping, centralized food service, central supply departments are now being organized on such a basis.

I have laid stress, or at least have attempted to do so, on the need for a cautious approach to hospital labour problems. If management and labour patiently co-operate in the struggle to raise the standards of hospital care while keeping hospital costs within a justified range, there is every reason to expect that over and above the particular advantages of stability of hospital employment and the opportunity it offers to serve others, there will also result increased remuneration and benefits for employees. Fewer, better trained, efficient, well paid employees who will have heard the call to service when they crossed the threshold of the personnel director's office will stand ever ready to serve the needs of the sick and injured. "The charity of Christ urges us on". We have made ours this motto of the Catholic Hospital Association and with our co-workers at all levels may we make it a challenging call to action.

English Nursing Uniforms

(Concluded from page 82)

the hospital authority wishes them to be worn, they should cover the whole of the hair and be so designed that they open flat for ironing. It is also felt that an apron should be part of the uniform, since it protects the dress and is cheaper to change daily than a dress. Overalls are recommended where the majority of the staff live out.

The conclusions drawn by the report about female nursing uniforms are also intended to apply to those worn by male nurses. The design should be as plain as possible, all pleats being avoided. For domestic staff, a wrap-over skirt overall, economical to launder, is thought to be suitable.

The history of nursing uniforms, the report concludes, had shown that changes have come gradually and have mainly been in the length of the skirt and number of frills. It suggests that the subject now be approached with the emphasis on laundry costs.

Limitations

No one of us escapes limitations . . . Some people are gifted with their hands, some people are gifted in the realm of art or music, some people are gifted in the realm of abstract ideas. Almost no one is gifted in all three realms. We are all limited and we must accept ourselves with our limitations, recognizing that we can do what others cannot do, that we can contribute where others cannot contribute.—*Joshua Loth Liebman*

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MILDNESS—Encore's rich, abundant lather cleanses thoroughly, yet rinses easily. Even the tender skin of a new-born infant is as safe in Encore as in water alone. *No soap is milder!*

PURITY—Because Colgate uses only the highest quality ingredients, and adds no "extra" ingredients, Encore Soap meets the highest hospital standards for purity.

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Respirators Available Through Poliomyelitis Emergency Equipment Register

On the recommendation of the Dominion Council of Health at its meeting in the fall of 1953, the Department of National Health and Welfare has established a register of respirators for use in poliomyelitis cases suffering respiratory embarrassment. This action was motivated by experience during the severe epidemic of 1953 when the demand for respirators in a number of the provinces, particularly Manitoba and Alberta, outran the supply available and necessitated borrowing such equipment from adjacent areas.

The purpose of the compilation is to have readily available a more or less complete list of respirators in each of the provinces to permit, should circumstances necessitate, the ready determination of available units and to expedite their transfer between provinces.

Early in July each province provided a list of respirators at its disposal indicating the number of units of each type, size, location in the province, and whether or not they were in use at the time. These lists were consolidated and a copy was sent to each provincial health department. The list was revised in late August and copies were forwarded again to the provincial health agencies. Thus, appropriate officials are acquainted with current availability of this equipment and, in addition, more detailed lists of the specific location of individual respirators are maintained by the federal health department.

Fortunately, the mildness of the poliomyelitis situation in most of Canada this year has not necessitated any great activity so far as transfer of respirators between provinces is concerned, but in August through the use of the register, arrangements were initiated for the loan of three such items of equipment by the Province of Ontario to the Quebec Health Department for use during a flare-up in the Chicoutimi area.

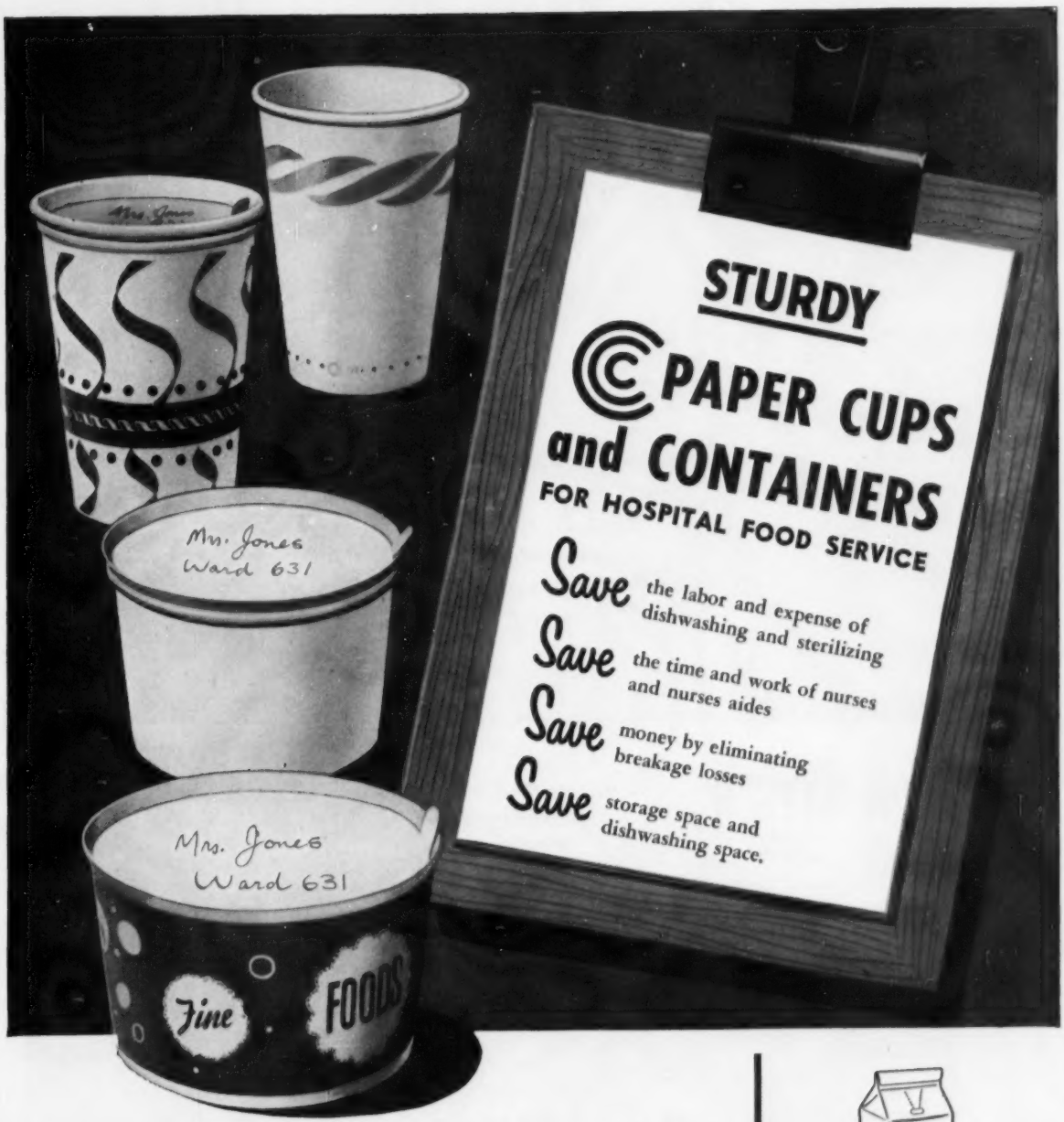
At first it was thought advisable to set up a similar list of other emergency poliomyelitis equipment. However, since most of these items have use in a variety of medical and surgical conditions and their transfer from one hospital to another institution outside a province, even on a temporary basis, might result in some embarrassment to the hospital concerned, it was decided to limit the register of emergency equipment to respirators only and their accessories. In the event that other types of equipment might be needed in any area, means have been devised for ascertaining availability in other provinces.

The recommended procedure in obtaining respirators follows a more or less standard pattern. The health officer in the area affected would simply advise the provincial health department of the local need, although this step would probably be unnecessary since the provincial authorities would undoubtedly be closely in touch with the situation. After consulting the register of respirators negotiations would be carried on between the provincial health department and the health authorities in another province in which respirators might not be in demand and arrangements made for transfer between the two provinces.

The matter of transportation poses a rather awkward problem. Frequently the need arises as an emergency measure and air freight would be most desirable. However, most respirators are bulky and very weighty and cannot be carried in the ordinary passenger plane. Where a transfer is being made between two adjacent provinces, usually rail express is a satisfactory substitute in terms of time, facility in handling and cost. As is reasonable, the "borrowing" province or community is expected to cover the cost of shipment and return of the respirator and to assure its maintenance in good condition.

The Greatest Gift

The greatest gift . . . is the realization that life does not consist either of wallowing in the past or peering anxiously at the future; and it is appalling to contemplate the great number of often painful steps by which one arrives at a truth so old, so obvious, and so frequently expressed. It is good for one to appreciate that life is now. Whatever it offers, little or much, life is now, this day, this hour.—*Charles Macomb Flandrau*



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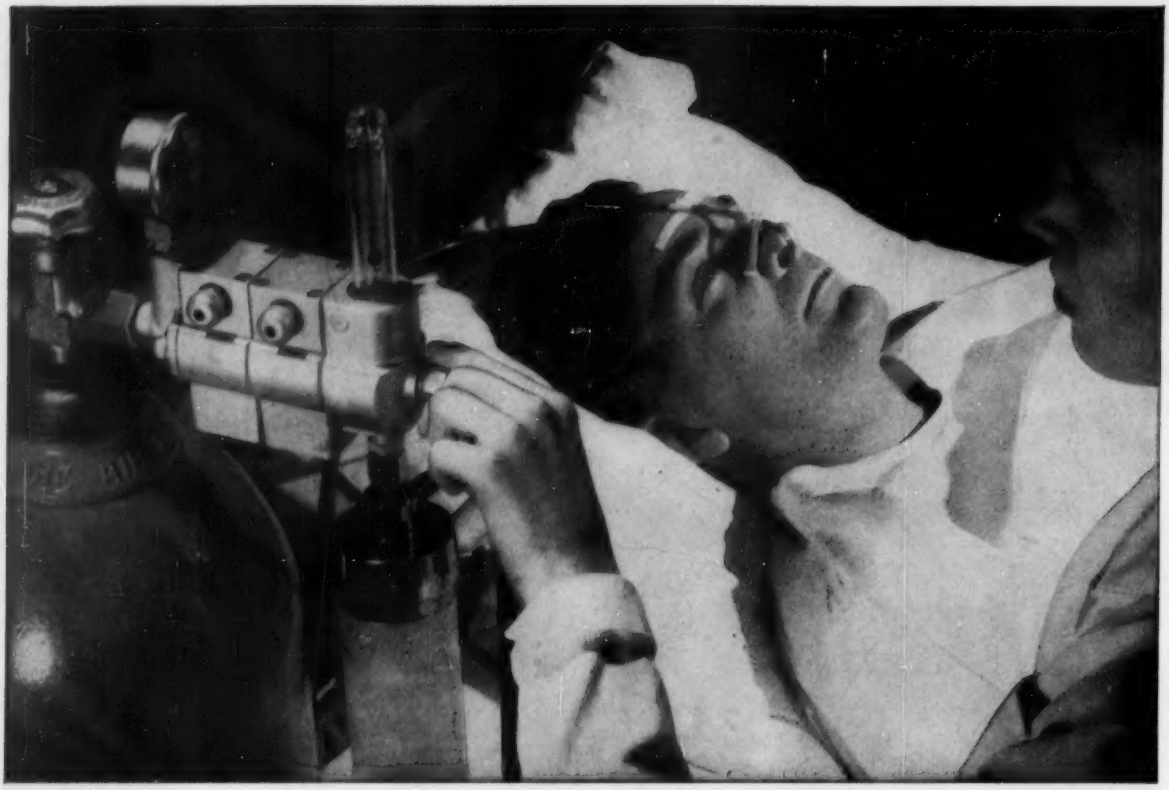

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Transfer of oxygen from the cylinder to the lungs of the patient is the most expensive item in oxygen administration. Oxygen that a patient actually receives accounts for only a small percentage of the total cost. But getting oxygen from the cylinder and into the lungs involves the cost of cylinder handling, apparatus amortization, maintenance, and repair, and labor. Wasted oxygen also increases administration costs.

In any given area the price of oxygen does not vary more than a few cents per hundred cubic feet. Therefore, the important savings in oxygen administration are to be made by eliminating wastage, reducing cylinder handling, and cutting the cost of apparatus maintenance and repair through more efficient operation.

Through literature, motion pictures, demonstrations, and personal surveys, Dominion Oxygen can help you to develop more efficient, economical methods of oxygen administration in your hospital. Consult your Dominion Oxygen representative about any mechanical problems involving the demonstration of DOMINION oxygen B.P. in your hospital.

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▼ New Orleans

Mercy Hospital, New Orleans, one of the fine new hospitals of the South, built by Sisters of Mercy who operated Mercy-Soniat Memorial Hospital in New Orleans for many years.

Keeping pace with Toronto's growth, the new Mount Sinai Hospital provides the most modern medical and surgical facilities available.

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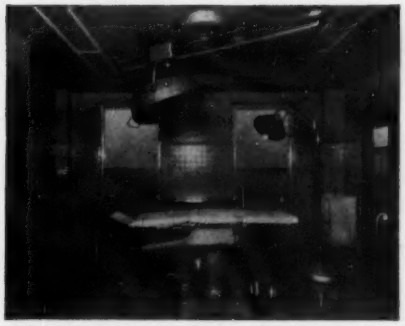
Architect: Vincent G. Kling.

▼ Philadelphia

One of the new and luxurious hospitals in the East, Lankenau Hospital, Philadelphia, is designed to establish a new pattern of hospital care.



MERCY—typical operating room in this modern institution is equipped with Castle overhead major surgical light and explosion-proof floor light.

MOUNT SINAI—Sub-sterilizing room between operating rooms showing carefully planned installation of cabinet-type Castle Hi-Speed Instrument Sterilizer and Liquid Heating Cabinet.

GIANTS ALL—these cities and their hospitals! Mercy, Mt. Sinai, Lankenau—each miles apart—yet each with a single common purpose—the care, healing, protection of its own.

In New Orleans, Toronto and Philadelphia these three have risen to help carry on the work of older hospitals.

Because they are modern, progressive, the equipment which goes into them is modern, modern in concept, modern in design.

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CASGRAIN & CHARBONNEAU, LTD., MONTREAL

Nora-Frances Henderson

(Concluded from page 47)

where all foods and beverages for patients will be served and distributed to the wards by food carts.

Lawns

On the elevated lawn east of the building, lighting outlets have been installed for use during garden parties or band concerts. A ramp from the first floor dining room enables all patients to be moved out onto the lawn.

All planting in the grounds has been carried out in accordance with a carefully planned design. Attractive lawn areas are interspersed with trees and shrubs for shade and the whole is laid out to provide long vistas when the trees are fully grown. Grades have been brought up almost a full storey in height at the centre of the east and west walls of the building to eliminate steps at the entrances. At the north and south ends of the hospital, doors lead out at grade level from the ground floor. Equipment can be brought directly into the patients' building through these latter entrances and deliveries of stores are made through a depressed area at the west, between the auditorium and the administration building.

Formal opening of the Nora-Frances Henderson Hospital took place on October 14th and many guests viewed with interest the handsome and comfortable institution they had helped to provide. Experience in the operation of this hospital is awaited, also, with interest and it is hoped that it can, and will, fulfill the purpose for which it was designed.

New drug may prove useful to treat chronic gout

A new synthetic drug, which does not have the hormonal effects of cortisone, has been shown to exert anti-rheumatic effects in gouty arthritis and rheumatoid arthritis. Recently introduced, the drug, G-25671 (a Geigy compound), is a derivative of phenylbutazone (Butazolidin). It exerts a less powerful anti-rheumatic effect but does not cause retention of sodium and water, thus showing that there is a possibility of eliminating at least one harmful effect of phenylbutazone. In addition, the new compound lowers blood uric acid to a marked degree by causing its excretion in urine.

This work is part of a program to develop a drug retaining the anti-rheumatic action of phenylbutazone but devoid of its side effects. A series of drugs is being screened in animals and man for anti-inflammatory activity. If further experimentation should indicate that the new drug has such low toxicity that long-term administration is feasible, G-25671 with its combined anti-rheumatic and uricosuric effects may prove useful in treatment of chronic gout.—*U.S. Public Health Service.*

The "Little Things"

A little perfume creates a lot of atmosphere. An ounce of the active ingredient in a new mosquito spray treats an acre of marsh. One thirty-millionth of an ounce of Vitamin B_{12} halts pernicious anaemia. The "little things" carry a big punch if they are used in the right way.—*"C-I-L Oval", Aug., 1954.*

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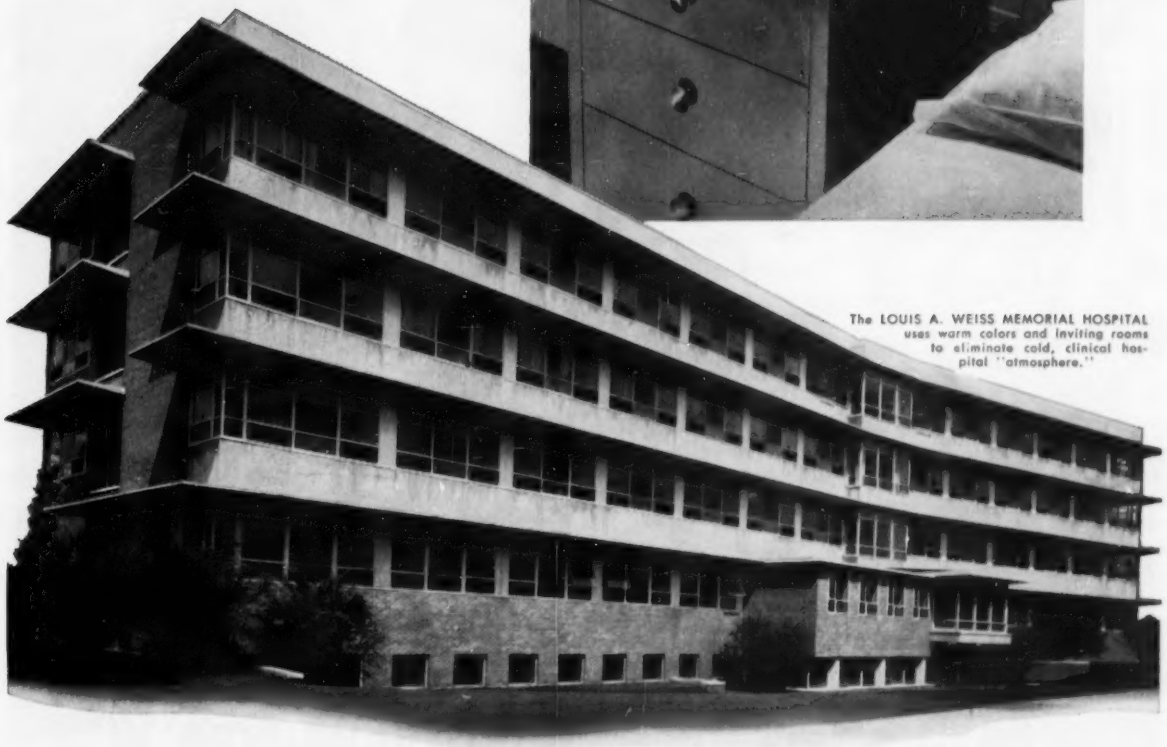
for today's advanced standards . . .



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A complete assortment of Heinz famous Pickles, Relishes, Dressings and Olives are available in 105 oz. and 128 oz. containers. They enable you to "dress up" meals with spicy, satisfying garnishes.

Ask your Heinz man to show you actual serving costs on these famous Heinz foods. 57

VM-14

HEINZ Bulk Packages

Sales Tax Question Box

(Rulings from the Department of National Revenue, Excise Division)

Q—Is a hospital allowed to sell drugs to doctors, nurses and hospital staffs without accounting for sales tax thereon if the charge does not exceed 10 per cent over cost?

A—No. If a hospital purchases drugs, dressings and other taxable goods under a certificate that the goods so purchased are not for resale, and if they are sold to the persons mentioned, sales tax is to be paid; where a charge is made to patients, however, and such charge does not exceed 10 per cent over cost, the Department has permitted exemption from sales tax on such sales.

* * *

Q—Is the tax applicable on purchases made by a committee conducting a campaign to raise funds for a *bona fide* public hospital?

A—Yes, in view of the specific wording of the provision for exemption from sales tax for *bona fide* public hospitals contained in the Excise Tax Act, it is necessary to restrict the exemption to direct purchases by such hospitals of articles and materials for their own use and not for resale, under certificate to that effect.

* * *

Q—Is the tax applicable to equipment, tools and items of similar nature used by a contractor in the execution of a contract obtained from a *bona fide* public hospital?

A—Yes, the exemption applies only to those articles and materials forming an actual component or constituent of the hospital building when, of course, obtained by the hospital in accordance with Departmental regulations. The exemption does not extend to construction machinery, heavy equipment, rolling stock, tools and the like, nor to articles and materials for the operation of or repairs or replacements to such equipment, nor to other articles and materials which do not form an actual integral part of the work.

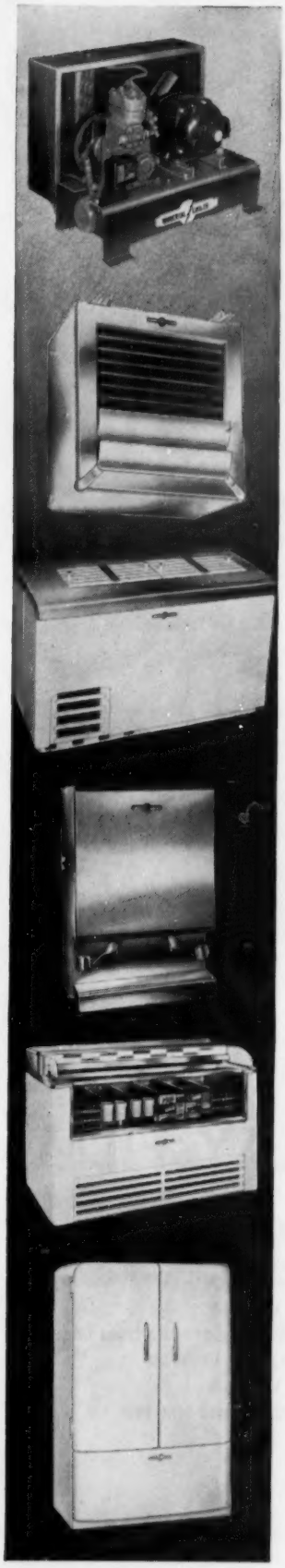
* * *

Q—Are supplies purchased by some committee or other welfare organization, for use in the operation of a chest clinic or rehabilitation program, taxable?

A—Yes, as outlined above in answer No. 2, the exemption extends only to articles and materials purchased directly by a *bona fide* public hospital for its own use and not for resale, under certificate to the foregoing effect.

Live Each Moment

As I got older I became aware of the folly of this perpetual reaching after the future, and of drawing from tomorrow, and from tomorrow only, a reason for the joyfulness of today. I learned when, alas, it was almost too late, to live each moment as it passed over my head.—*William Hale White*



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Technical Perfection

A medical radiograph must give a true picture. And to be true, the picture must be technically perfect because faults lead to ambiguity and error. Five factors are necessary for technical perfection:

I The subject should be easy to recognize and it should conform to one of the recognized positioning standards.

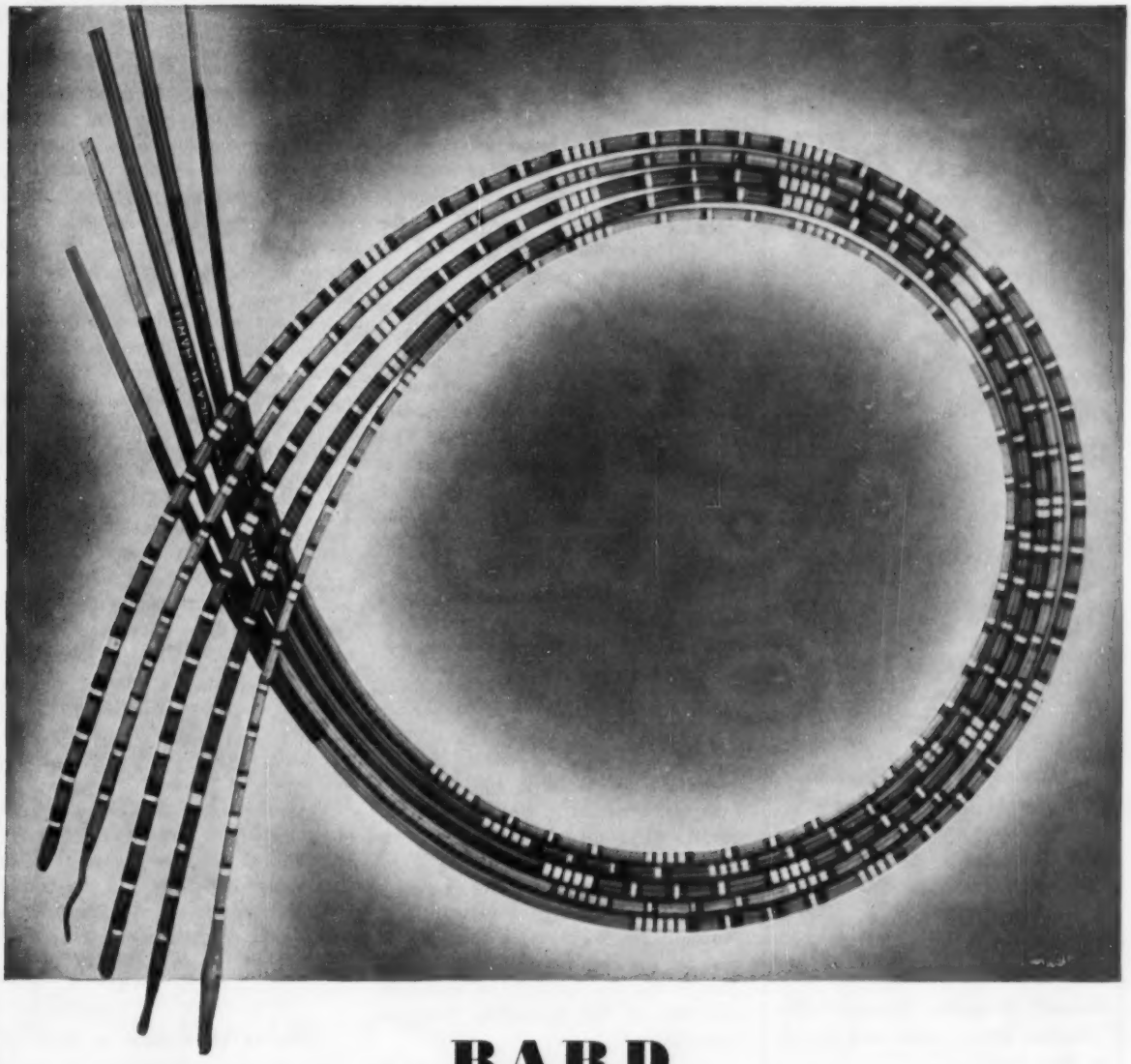
II Its definition must be good enough to show outlines and structural detail clearly and unmistakably.

III The whole range of opacities in the subject should be represented by a corresponding range of densities in the film.

IV Identification must be correct, easily read, not too obstrusive, neatly placed and permanent.

V The finished film must be clean, free from scratches, spots and other accidental markings.

There may be times when an intentional or accidental departure from the first three requirements is acceptable, but in general it is safer practice to adhere rigidly to these desiderata.



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"Efficiency With Economy"—Convention Theme In Ontario

The end of October is always a busy and important time for hospital leaders in Ontario as that is when the Ontario Hospital Association holds its annual convention. This year the dates are Monday, Tuesday, and Wednesday, October 25, 26 and 27 — the scene is, as usual, the Royal York Hotel, Toronto.

This year the theme is a challenging one, "efficiency with economy", and it is to be expected that there will be much interest in how to accomplish it. Subjects such as "Partners in Hospital Service" (Monday) and "What Can We Do about Hospital Costs?" (Tuesday) should help to provide some of the answers. A very interesting feature on Wednesday will be a demonstration, entitled "Accreditation and Your Hospital", presented by Dr. Harry A. Nevel of the United States and Dr. Karl E. Hollis of Toronto, both hospital accreditation field surveyors.

The president, William M. (Bill) Gray, will welcome the delegates, and Hon. Paul Martin, minister of National Health and Welfare, will officially open the convention, which is the Association's 30th. Greetings will be brought for the first time by Fred Gardner, chairman of the recently formed Municipality of Metropolitan Toronto. Dr. W. Douglas Piercey will, also for the first time, greet the delegates in his new capacity as executive director of the Canadian Hospital Association.

As in other years, there will be over 100 exhibits of hospital supplies, equipment, and services. These are always a major attraction to delegates who are ever looking for new ideas. Then there will be the seven separate section meetings — trustees, nursing administration, accounting, dietetic, medical record librarians, women's hospital auxiliaries, and pharmacists. These take place on Tuesday morning except for that of the pharmacists who begin their session at noon with a luncheon. Most interesting topics and excellent speakers have been arranged by the section officers.

Some outstanding speakers are to be present, *e.g.*, Dr. Frank R. Bradley, president of the American Hospital Association; Harry C. Becker, associate director, Commission on Financing of Hospital Care, Chicago, Ill.; Lucy D. Germain, Reg.N., director of the department of nursing and nursing education, Harper Hospital, Detroit, Mich.; Dr. R. M. Mitchell, president of the Ontario Medical Association; M. McIntyre Hood, managing editor of the Oshawa Times-Gazette; Dr. C. W. M. Service of Lindsay, Ont., and many of our own provincial hospital personnel.

Tuesday evening there will be the annual banquet followed by a floor show, dancing, and cards. The banquet will be especially interesting this year for, in addition to the installation of the new president, there will be the presentation of the George Findlay Stephens Memorial Award to Arthur J. Swanson, by the Canadian Hospital Association.

One of the highlights this year will be a president's reception on Monday evening at the Association's headquarters, 135 St. Clair Avenue West, Toronto. Delegates, guests, and exhibitors will spend a social period together and be taken on a tour of the building, after which refreshments will be served.

The program committee, under the chairmanship of Mrs. Charles McLean, has worked hard to assure that the convention delegates will find their time well spent. It is expected that over 2,500, including exhibitors, will register.—*A. George Ferchat*

Keeping wheel chairs in repair

Like any other piece of equipment, wheel chairs need regular inspection and repair. Of course, each chair should be inspected by the nurse before it is used; and if anything needs repairing, the chair should not be used. However, the chair should be regularly inspected by the maintenance department.

Wheels should be checked to make sure that they are on securely and turn easily. Leg rest bearings should be checked. The stops under the leg rest and under the back which prevent the chair from tipping should be checked to make sure that they are secure and in place.

If the wheel chair is of the folding kind, in addition to the points above, the hinges and locks should be checked to make sure that they are solid. — *Hospital Safety Service News Letter, Aug., 1954.*

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Le Coût d'Hospitalisation

(Suite de la page 37)

retourner dans son foyer la dixième journée après son intervention, alors qu'autrefois un séjour de trois semaines était de règle quand il n'y avait pas de complications. Or de là à conclure que, si nous n'avions pas été à la hauteur de la tâche, le nombre de lits au Canada serait beaucoup plus élevé que celui que nous avons présentement, et le coût d'hospitalisation, lui . . . . car, où prendrions-nous tout le personnel nécessaire et à quel prix l'aurions-nous? Je n'insiste pas, car je sais, que bien avant moi, vous avez saisi la relation étroite qui existe entre les succès du corps médical et le coût d'hospitalisation.

Je parle toujours du corps médical et je me plais à raconter ses prouesses. C'est probablement par déformation professionnelle, car mes maîtres d'autrefois m'ont bien recommandé la pratique de l'humilité, mais ils m'ont enseigné aussi l'esprit de justice. En ce moment, je me pose une question: laissés à eux-mêmes, les médecins et les chirurgiens sauraient-ils pu accomplir tous ces faits d'armes? Je m'empresse de répondre, non. Si la victoire a été si belle, c'est que l'administrateur et le médecin forment une équipe comme il s'en voit rarement. C'est que tous deux, médecin et administrateur, en face du malade qui se présente à l'hôpital et qui demeure toujours leur premier souci, savent, d'un commun accord, mettre en branle toutes les découvertes réalisées par la science moderne, tant dans la construction et l'aménagement des hôpitaux, que dans l'art de traiter les maladies. On ne peut décerner une couronne de lauriers aux médecins, sans présenter en même temps aux administrateurs, aux propriétaires d'hôpitaux, à notre soeurs, le même hommage et le même symbole de gloire.

(à conclure en novembre)

World's Post-war Housing Problems

According to a United Nations Survey, the world-wide trend to migrate to the cities has resulted in almost unbelievable overcrowding. In Bombay, India, for instance, tenements average more than seven persons per room. In Panama, as many as 20 persons occupy a room of 15 feet by 15 feet, sleeping in relays. Space is so scarce in Bolivia that a single room in a crude cabin must serve one or more families and their domestic animals. An official survey, in Istanbul, Turkey, showed that the number of persons per dwelling increased from 5.95 in 1927 to 9.49 in 1950.

Yet, contrary to popular belief, there is really no scarcity of land for cities, if only they were properly planned. Indeed, the earth's entire population could be housed at a density of 25 to the acre on the 143,000 square miles of Germany. The population density on Manhattan Island, New York City, is 136.

National Nurse Week

The week of October 11-16 was proclaimed National Nurse Week, by United States President, Dwight D. Eisenhower. The two-fold purpose of the week was: to honour nurses who, day in and day out, in hospitals, at home, in the factory, at school, and in the clinic, help to guard the nation's health; and to illustrate that progress in nursing means better health for all.

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When that time comes, and it may be sooner than you now think, it's only good business to look around—to select not only a fine product, but what is more important, to choose one backed by a *Company, with a reputation for dependable service and fair dealing.*

An outstanding and unusual example of such a highly respected Product and Company, is the name BERKEL—pioneer in the Slicing Machine field, and now offering a Complete Line of Food Processing Equipment.

Yes, *for real satisfaction—to get the most for your buying dollar*—the name BERKEL is truly "well worth remembering"—popular choice of leaders in the field for over half-a-century.

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Saskatchewan Hospitalization Rate To be Unchanged for Next Year

Saskatchewan's hospitalization tax rates for 1955 will be the same as those in effect this year, it was announced recently by the Hon. T. J. Bentley, provincial minister of health. These rates are as follows: for each self-supporting person or a spouse (including a widowed, divorced or separated person)—$15; for every person who reaches the age of 18 years before January 1, 1955—$15; and for each dependent child under 18 years—$5.

The family maximum is $40, *i.e.*, the maximum tax for a taxpayer, his spouse, dependents under 18 years, children over 18 who are incapacitated by reason of physical or mental infirmity, and dependents over 18 but under 21 years as of January 1, 1955, who are attending educational institutions or training at a school of nursing.

Where the total tax payable is $20 or less the full amount must be paid by November 30, 1954. If the tax payable is more than $20 that amount is due by November 30, 1954, and the balance by May 31, 1955. New residents of the province are taxed on a *pro rata* basis from the first of the month following completion of six months' residence.

Benefits of the Saskatchewan Hospital Services Plan, which include payment for most services ordinarily required during in-patient hospital care, depend upon prior payment of the hospitalization tax.

In each of the past several years, Mr. Bentley said, the plan has paid about one hospital bill for every five persons in the province. Within the province no limit is imposed upon the length of hospital stay covered by the plan other than that of medical necessity for in-patient care. Outside Saskatchewan, payments by the plan are made at a rate of $7.50 a day for adults and $1.50 a day for newborns for a maximum of 60 days in the year. The present level of out-of-province benefits which became effective January 1, 1954, represents a 50 per cent increase over the previous rates. — *Saskatchewan "News"*

* * * *

Enrolment up for Ontario Blue Cross

The Ontario Hospital Association's Blue Cross Plan experienced an enrolment growth of 67,000 new participants during the first four months of 1954. During the same period, $13,740,000 was paid to hospitals in subscriber benefits. At the same time, the percentage of income required for administration expense reached a new low of 6.3 per cent.

Blue Cross membership in Ontario now exceeds 1,892,000—about 40 per cent of the population. Since the Plan began on March 17th, 1941, the total value of subscriber benefits covered is in excess of $107,000,000. There was an upward trend in the first half of 1954 in the number of participants receiving benefits. Where the average number of members hospitalized in 1953 was 172 of each thousand, this figure was 182, up to June 30th, 1954. In all, 168,000 Blue Cross participants required hospital care in the six-month period.

Federal Authorities Urge Care with Household Chemicals

Officials of the food and drug division of the Department of National Health and Welfare urge greater care in handling drugs and household chemicals, particularly in homes with small children. Statistics show that over one-quarter of the deaths from accidental poisoning in 1952 had occurred in children under four years of age. Of these deaths, over one-third were caused by the accidental swallowing of substances which were not drugs, including household chemicals such as kerosene, turpentine, and lye. In addition, mothers were warned to avoid administering medicine of any kind to children under two years of age, without medical advice.

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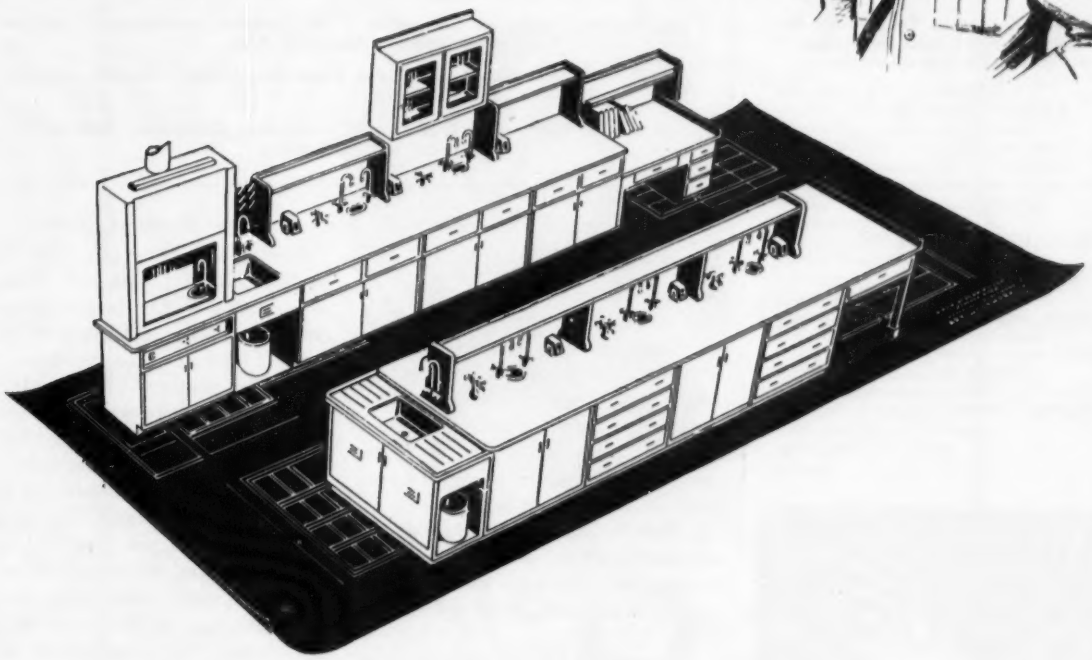

Equipment Planning and Consulting Service

A variation of even a few inches in the location of any of the main service line outlets leading into a laboratory can disrupt an entire arrangement.

Because all these service lines *must* fit, in their proper relationship, within the framework of the cabinet, *the importance of early planning* to assure the proper positioning of the outlets is readily understandable.

Our planning Department is designed to render this service. In its files are over 1,300 equipment layouts reflecting the experience of chemists, educators and architects and demonstrating the continuing development of efficient layout in relation to modern laboratory technique.

You may benefit from this composite experience.

Our representative will study your requirements with you and plans will be drawn showing suggested equipment and arrangement in conformity with his report.

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Coming Conventions

Oct. 12-15—Annual Convention of the British Columbia Hospitals' Association, Hotel Vancouver, Vancouver, B.C.

Oct. 20-21—Annual Meeting of the Catholic Conference of Alberta, Edmonton,

Oct. 25-27—Ontario Hospital Association Convention, Royal York Hotel, Toronto, Ont.

Oct. 25-27—Annual Convention of the Canadian Association of Medical Record Librarians, Royal York Hotel, Toronto, Ont.

Oct. 28-29—Annual Meeting of the Ontario Conference of the Catholic Hospital Association, St. Joseph's Hospital, Toronto.

Oct. 30-Nov. 1—Annual Convention of the Canadian Association of Occupational Therapy, Montreal, P.Q.

May 9-11, 1955—Canadian Hospital Association Biennial Meeting, Chateau Laurier, Ottawa.

Sept. 19-22, 1955—American Hospital Association Convention, Atlantic City Convention Hall, Atlantic City, N.J.

Consent for Operations

(Concluded from page 66)

necessary. Obstetrical cases, however, often require the use of forceps, an episotomy, or other procedures; thus consent should be given for the procedure of delivery. Naturally, if a caesarian section, surgical induction, or other special procedure is to be done, such procedure should be specified on the consent form.

3. *Does the signed consent for operation cover only the original or does it also give permission for successive operations in the same period of hospitalization?*

The answer to this was actually given under question 1. By and large, each successive operative procedure calls for specific consent by the patient. There may be exceptions to this wherein a person on admission can be informed that he will require two or more operations. In such cases, these may be listed on the original consent form. However, where the patient has signed permission for a certain specific procedure and later, during his hospitalization, another specific procedure becomes necessary, a separate operation consent form should be signed and witnessed.

In conclusion, I would like to refer to an excellent article on "Consents for Operations and Anaesthetics", by S. W. G. Ratcliff, M.B., Ch.M., F.I.H.A., F.I.H.S., of Melbourne, Australia, which appeared in *The Canadian Hospital*, November, 1952. A suggested consent - for - operations form, which was included with the article, is repeated on page 66. ●

New "Rooming-in" Idea

Among the ideas put forth by a Belgian architect, Maurice Hosdain, in a lecture to the Belgian Hospital Association was one for a new "rooming-in" type of accommodation for babies in mothers' rooms. In the private wards there was a bed for the mother and a glass cubicle for the baby. By this means, the baby was constantly near the mother but could not disturb her rest. The mother, moreover, could see just how much care and attention was given to her child and could also learn how to look after him. In the wards the plan was similar. The glass cubicle, in the middle, contained four cots, two on either side of an opaque glass partition, and the mothers' beds were grouped around it so that each could watch her own child. — *"Hospital and Health Management", August, 1954.*

Tomorrow's Load

The load of tomorrow, added to that of yesterday, carried today makes the strongest falter . . . Waste of energy, mental distress, nervous worries dog the steps of a man who is anxious about the future. Shut close, then, the great fore and aft bulkheads, and prepare to cultivate the habit of a life in "day-tight compartments"! I am simply giving you a philosophy of life that I have found helpful in my work. In this philosophy or way of life each of you may learn to drive the straight furrow, and so come to the true measure of a man.—*Sir William Osler*

Medical Record Department

(Continued from page 78)

vious admissions of all patients.

5. Type information from admission sheets on patient's file card as follows: name, address, next of kin, date of birth, phone number, date of admission, hospital number, and name of attending doctor.

6. If patient has been re-admitted, bring forward previous chart and place it in folder under *new* admission number. Write *new* admission number clearly on folder from which previous record has been removed and leave folder in file as a guide.

7. File patient's card alphabetically in "In-Patient" active file.

8. Obtain list of admitting diagnosis from admitting officer and enter diagnoses in admitting ledger.

Discharges

When charts of discharged patients are received in Medical Record Department, we proceed as follows:

1. Assemble each chart in proper chronological order.

2. Compile "Discharge List", showing date at top of list, and (a) name of patient (specify Mr., Mrs., or Miss, if adult), and chart number; (b) if patient expired, type name and number in red and specify time of death; (c) if babe remains in hospital after mother is discharged, type "babe remains" on discharge list.

3. Enter date of discharge in admitting ledger.

4. Pull cards of discharged patients from in-patient active file.

5. Type date of discharge on patient's file card—if patient expired, type in red.

6. Type final diagnosis on patient's file card.

7. File patient's card in Master File in alphabetical order.

8. Tick upper right hand corner of chart when items 5 and 6 above are completed.

9. If final diagnosis is not available, file patient's card in "Temporary File". When diagnosis is obtained, remove card from temporary file, enter diagnosis, and file card in Master File.

10. Compare discharge list daily with list of discharges received from general office, and check discrepancies. Make necessary changes or corrections, and notify general office.

Checking

All medical records must be checked for the following, and errors or omissions noted on "Incomplete Record" slip which is attached to every chart:

1. Spelling of patient's name, and correct hospital number on all pages of record.

2. Complete history, physical examination, and progress notes.

3. Final diagnoses, and signature of attending physician.

4. Operation report and signature of surgeon.

5. Anaesthetic report and signature of anaesthetist.

6. Doctor's Orders—check for reports of all tests ordered, and if reports are missing, obtain copies from laboratory, x-ray, or department concerned.

7. Consent form as to Major or Minor operation—signature of patient, or signature of parent or guardian in case of a minor.

8. Nurses' Notes—date and time of admission and discharge.

9. Hospital infection. If infection

(Concluded on page 120)

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The Canadian Hospital Association has published an attractively designed brochure to illustrate the tax exempions that are allowable on charitable gifts to hospitals. It is published as an aid to hospitals in encouraging philanthropy through individual or corporate gifts.

Supplies of the brochure, printed either in French or in English, are now available for use in your community.

Quantities of less than 100 copies	7c each
100 to 499 copies	6c each
500 or more copies	5c each

Imprinting of your hospital name and address on the front cover of the brochure may be done for a charge of $7.50 irrespective of the quantity ordered. Kindly stipulate on your purchase order if imprinting is desired.

Orders may be placed with, or a sample obtained from: Canadian Hospital Association, 280 Bloor Street West, Toronto 5, Ontario.

NOTICE

There is one important exception concerning the information contained in the Canadian Hospital Association brochure, *Tax Savings Reduce the Cost of Donations to Hospitals.* This exception applies to the province of Quebec where the subject of provincial-federal taxation is at present under review. Until the matter is clarified the Canadian Hospital Association does not consider it advisable to distribute sample copies of the brochure to hospitals in the province of Quebec.

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The Broyles Optical Bronchoscope consists of the following:

Foroblique* examining telescope, providing magnified image of lesions in direct view.

Right angle examining telescope, permitting clear, magnified image of upper lobe bronchus and subdivisions.

Retrograde examining telescope, giving retrospective view of lower portions of lesions of trachea.

Operating telescope, providing clear, magnified image directly at jaws of *Biopsy Forceps* or *Grasping Forceps.*

Bronchoscopic tubes are supplied in lumen sizes 3, 4, 5 and 6 mm., 30 cm. long and with 7, 8 and 9 mm. lumen, 40 cm. long. Each tube includes a separate interchangeable light carrier. Also included, is a set of anti-fogging attachments.

The Broyles Optical Bronchoscope is available as a complete unit; or the individual telescopes, forceps, tubes and other components may be obtained separately.

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Medical Record Department

(Concluded from page 118)

suspected, check with attending doctor.

10. Consent for autopsy, and copy of autopsy report in case of death.

11. Place incomplete histories in cubicles for attending doctor. Set aside other incomplete records until copies of missing reports are obtained from other departments.

12. Complete records are ready for coding and indexing, and are subsequently filed in Permanent File.

Hospital Insurance Service

1. When provincial hospital insurance forms are brought to the medical record department from general office, enter provisional diagnoses (as recorded in Admitting Ledger) in space "Diagnosis on Admission" and return form to general office.

2. Provincial hospital insurance forms are brought back to the medical record department when patients are discharged. Complete "Discharge History" section from information on patients' records and return insurance forms to general office.

Coding and Indexing

1. Code according to Standard Nomenclature of Diseases and Operations, and complete diagnostic slip for each disease and procedure.

2. Arrange slips in numerical order, according to systems.

3. Pull index cards from disease index and type information from slips.

4. File index cards.

5. Same procedure applies to coding operative procedures.

Statistics

1. Enter statistics (except deaths) daily on worksheet, according to services. Record paediatrics according to age group (age 9-14, and 8 years and under) on this worksheet.

2. Enter paediatric cases (except deaths) on special paediatric worksheet according to services (medicine, surgery, E.E.N.T., urology and orthopaedics) in the two age groups.

3. Enter all deaths in pathology book, and also in record department ledger. At the end of the month, add deaths according to services to worksheet. Compile monthly report from worksheet.

4. Mark "X" in upper right corner of face sheet to denote that record has been entered in statistics or that death has been recorded in record department ledger.

5. Record special statistics in record department ledger (Section I, Item 7—Processing Medical Records).

6. Enter statistics for tissue committee in record book.

Filing

1. The medical record is numbered by the admitting officer when patient is admitted and, on discharge, the record is filed in the medical record department under this number.

2. When a patient is re-admitted, a new number is assigned by the admitting officer. Previous records are brought forward, combined and filed with the current admission under this new number.

Medical Audit

The medical record committee spot checks records on discharge of patients from hospital. However, the members of this committee hope to work out a method of reviewing all medical records, and it will be the responsibility of our department to provide the required statistics from a physicians' index which will be set up at that time. ●

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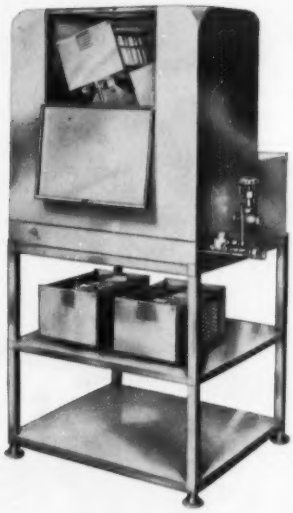

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• *Economical* • *Adaptable*

Ferris-like wheel holding four removable baskets rotates syringes, or other glassware, through hot detergent solution (temperature boosted by 2 immersion heaters) for remarkable ease of washing. Important safety factor in that personnel never touches contaminated glassware until processing is completed. When the syringes have been thoroughly washed and rinsed, syringe holder is removed from baskets for simple, predetermined matching of barrels and plungers before autoclaving. Normal washload of 4 full baskets requires 30-minute cycle for one wash, two rinses. Stainless baskets each hold 64 2cc syringes; 45 5cc syringes; 30 10cc syringes. Other baskets accommodate 20, 30, 50 and 100 cc syringes . . . as well as being equally adaptable to all Central Supply's small glassware . . . and even formula bottles.

Washer in bench model, or available on steel platform, optional at extra cost.

Installation requirements: hot water, drain, and 220 volt, 4500 watt, 60 cycle, single phase electrical connections. Steam heat model available.

Send for illustrated folders

Needle washer-rinser will process 700–1,000 needles an hour . . . compare this with your present needle washing requirements! Needles pre-soaked from floors in specially designed manifolds which are inserted, as is, into washer for ½ minute, then to rinser for ½ minute. Clean needles then emptied onto inspection tray before autoclaving. Drying cycle has been purposely omitted as unnecessary. Thus, the compressed air fixture and an extra bothersome step are avoided.

Hot detergent solution is forced down outside of needle shaft, then up through lumen and swirled through hub, eliminating vibration. Effects very superior cleansing with no dulling of needle points, as experienced with reverse flow cleansers.

All-important is the fact that your personnel will never come in contact with contaminated needles until processing has been completed.

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Toronto, Winnipeg, Calgary, Vancouver, Montreal.

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Provincial Notes

(Concluded from page 86)

of July 1st, entails the contribution by both hospital and employee of five per cent of the employee's basic annual earnings, the normal retirement age to be considered as 65 for males and 60 for females.

* * *

WALLACEBURG. Tenders have been called for the construction of the new Sydenham District Hospital and it is hoped that work on the building will get under way this fall. Present plans call for 71 beds and 24 bassinets. The hospital will be of brick, steel, and concrete construction and is designed for future expansion.

* * *

WOODSTOCK. The new wing, now under construction at the Woodstock General Hospital, has been designed to give an increase of 69 beds and 18 bassinets when it is completed next spring. The cost of the addition has been estimated at $1,563,000. One more floor can be added to the new wing if conditions in the future warrant further expansion.

Quebec

HULL. The city council has officially ratified an agreement between the city and the Sisters of the Sacred Heart for the construction of a $4,000,000, 240-bed hospital on Gamelin boulevard. The city has donated about 16 acres of land for the hospital site.

* * *

SWEETSBURG. Premier Maurice Duplessis officially opened the new Brome-Mississquoi-Perkins Hospital at the end of August. The new hospital has 68 beds for adults, a six-bed children's ward, and a 21-bassinet nursery. Designed by Edward J. Turcotte, architect, of Montreal, the new hospital replaces an older building which had been used as a hospital since 1910 and was formerly a hotel.

Nova Scotia

NORTH SYDNEY. Dedication ceremonies were held at the new St. Elizabeth Hospital in September. Open to receive patients since May, the new building replaces the former Hamilton Memorial Hospital. The hospital was built at a cost of $3,000,000 and has 185 beds and 32 bassinets.

Prince Edward Island

CHARLOTTETOWN. A contract has been awarded for the completion of a new treatment centre at Falconwood Hospital. The new building is a joint project undertaken by the Department of Public Works and the Department of Health and Welfare of the province. The centre portion of the U-shaped structure will run into a second storey, with the wings having only a ground floor. To be built of brick, stone, and steel, the centre will have accommodation for 86 patients and ample space will be allowed for equipment to treat short-term patients.

A.H.A. Convention

(Concluded from page 68)

matters of topical interest, such as the needs and distribution of care for the chronically ill, and the financing of top quality care through voluntary resources. In an interesting address, entitled "A Path to Your Door", Louis B. Seltzer, a newspaper editor, pointed out the public relations aspect of hospital costs and high quality care.

Personnel from small hospitals were given special attention at sessions planned to deal with matters of particular interest to them. Concurrent sessions, held in the morning, featured topics as varied as hospital planning, purchasing, staff relations, as well as financial and accounting problems.

The annual conference on hospital planning, sponsored jointly this year by the American Association of Hospital Consultants, American Institute of Architects, and the American Hospital Association, was held prior to the general meeting. Under the chairmanship of G. Harvey Agnew, M.D., Toronto, Ont., president of the hospital consultants' group, a panel of seven experts probed from several directions into the matter of planning a hospital. Topics included research in architectural design, care of the mentally ill, planning for long-term patients, and aspects of hospital organization.

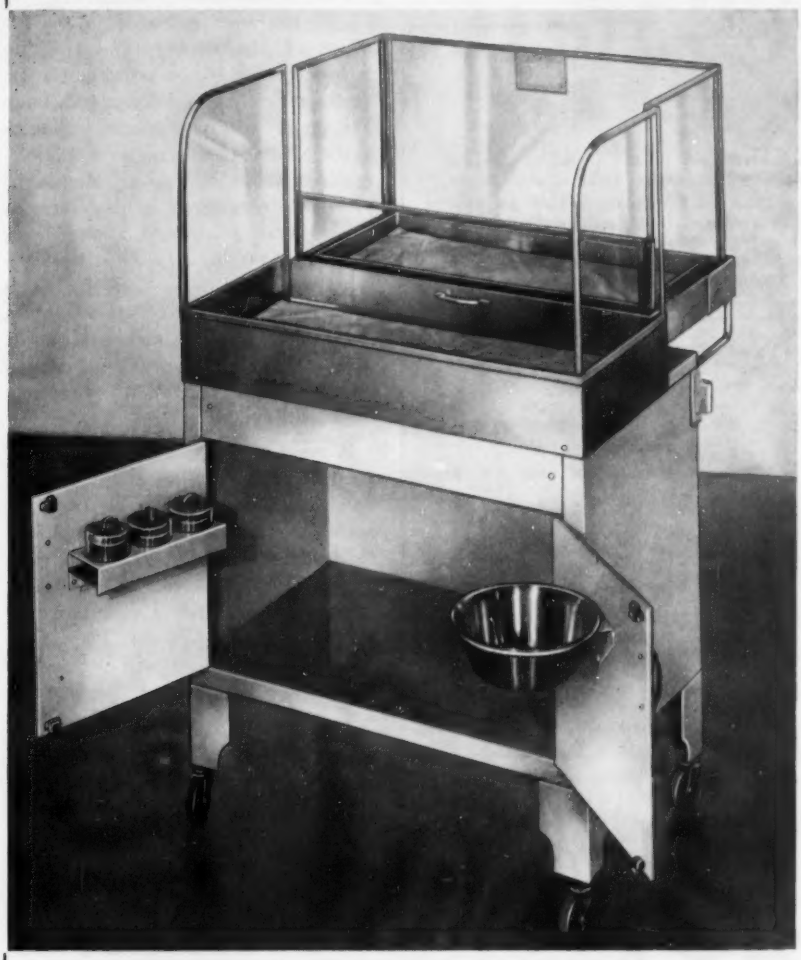
The huge hospital merchandise mart —the technical exhibit—shattered all records. More than 400 firms exhibited an amazing display of supplies, equipment, and services. The architects' exhibit featured model hospitals of every conceivable size and shape—all well-planned and executed.

A daily program of films attracted many. *Operation Ivy*, the Federal Civil Defence Administration documentary film on the 1952 atomic test at Eniwetok Atoll, was shown several times. Other interesting films featured a safety program, maternal and neonatal care, training personnel, and public relations. Throughout the convention, local radio and television stations gave excellent publicity. There were interviews with prominent hospital people, and panel discussions.

A memorable feature of the annual banquet is the presentation of the A.H.A. Award of Merit. This year's recipient was George Bugbee, president of Health Information Foundation, New York City, and former executive director of the American Hospital Association. The award was presented by Ritz E. Heerman, retiring president of the association. During the banquet, new officers were installed. Frank R. Bradley, M.D. director of Barnes Hospital, St. Louis, Mo., is the president for the following year and Ray E. Brown, superintendent of the University of Chicago Clinics, is the president-elect. John N. Hatfield, director of Passavant Memorial Hospital, Chicago, was re-elected treasurer.

Meeting Adversity

Just as we can immunize ourselves against certain bodily diseases by stimulating our reserves to overactivity by taking graduated doses of toxin into our bodies, so we can immunize ourselves against adversity by meeting and facing the unavoidable chagrins of life, as they occur. There may be happy human vegetables who have succeeded in avoiding unhappiness and pain, but they cannot call themselves men. — *W. Beran Wolfe*



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Federal Funds Aid Research

Federal assistance amounting to $5,020 has been extended to the Institute of Microbiology and Hygiene in Montreal, P.Q., to assist in studies on the efficiency of influenza vaccine. The studies will have special reference to the administration of aerosol booster doses through the nose. The use of vaccine administered in this form is a new and practicable approach to mass vaccination. One object of the research will be to compare the effects of aerosol-boosted vaccinations with those carried out in the conventional manner. The project will be carried out with the co-operation of a group of human volunteers.

A grant of $8,235 has been awarded the University of Toronto to carry out special research on the relationships between changes in the cerebrospinal fluid and mental illness. The year-long study will be carried out at the Connaught Research Laboratories of the University of Toronto. The largest portion of the grant will be used to employ highly-qualified professional staff and to provide essential research materials.

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Notes on Federal Grants

Construction

The Palmerston General Hospital at Palmerston, Ont., has been awarded a grant of $32,166. Construction plans call for a complete renovation of the old building and construction of an additional wing, increasing the bed capacity from 15 to 40. The new construction will also add 14 bassinets and three additional nurses' beds.

A grant of $8,000 will assist the Hôtel Dieu de Sorel, Sorel, P.Q., in the construction of additional residence facilities for 16 nurses.

Professional Training

Federal assistance of more than $31,700 has been approved to assist in developing facilities in Montreal for the training of physiotherapists and occupational therapists. The school, which will come under the supervision of the University of Montreal Faculty of Medicine, will work in co-operation with a number of Montreal hospitals. At present, facilities will be provided for 20 students annually and, eventually, it is planned that 40 students will be graduated each year. The federal government's contribution will help to provide qualified teaching staff and essential training equipment.

A new school for physiotherapists is being opened in Edmonton, Alta., this fall. The school comes under the supervision of the Faculty of Medicine, at the University of Alberta, and will train 30 students in a two-year diploma course. A federal grant of $13,138 has been awarded to help in the development of the new school.

Public Health

A grant of $10,728 has been awarded the City of Hamilton, Ont., for extensions to the city public health services. The grant will help to provide additional professional staff and to purchase laboratory and clinical equipment. A large portion of the grant will be used to obtain the services of a qualified public health veterinarian.

Seal of Approval for Fabrics

The multiplicity of fibres, fabrics, and finishes on the market today has created an urgent need for national standards in labelling garments. This year, the Canadian Research Institute is completing a small laundry and cleaning plant next door to its Ottawa headquarters. This pilot plant will enable the institute to launch a pet project—the pre-testing of fabrics and garments for serviceability in washing and dry cleaning before they are marketed. The seal of approval which such tests would award could be of value to the Canadian shopper. — *"C-I-L Oval", Aug., 1954.*

Education for Life As Well as for a Living

Any professional school has a dual task—to provide professional education and liberal education. Neither may be neglected. Technical instruction alone characterizes a mere trade school; whereas liberal education alone would not inculcate the specialized skills that the profession and the public have a right to demand.

. . . All kinds of professional schools are constantly subject to the temptation to fill up the time-tables of students, producing a treadmill of formal instruction, leaving no time for the students to develop the capacity to think by and for themselves, to exercise self-reliance and independent judgment, and to correlate their various studies. Teachers attempt to cover every variety of routine task, many of which can be learned better "on the job". They become obsessed with teaching their students the rules of thumb, the tricks of the trade, the "know-how" of their profession. But the primary concern of professional education is not the "know-how" but the "know-why". Professional schools must re-examine their curricula from time to time, to ascertain whether a study of principles is being sacrificed to practical work. As knowledge increases, and new sub-divisions develop in various subjects, the curriculum begins to strain at the seams; "something new has ben added" without anything being subtracted. It is needful to make sure that routine practical techniques are not absorbing too much of the students' time and, on the other hand, that the undergraduate years are not being filled with a smattering of special subjects which should rather be studied thoroughly in graduate courses. — *Sidney Smith, Q.C., M.A., LL.B., president of the University of Toronto, in the Bulletin of the Ontario College of Pharmacy, Sept., 1954.*

The Brave Man

Just as so many rivers, so many showers of rain from above, so many medicinal springs, do not alter the taste of the sea, so the pressure of adversity does not affect the mind of the brave man. For it maintains its balance and over all that happens it throws its own complexion, because it is more powerful than external circumstances.—*Seneca*

Montreal Hospitals Expand

A $125,000,000, 4,320-bed hospital building program, involving 20 city and metropolitan institutions in Montreal, is well on its way to completion. The various projects, excluding extensive expansion plans for local mental hospitals, will increase by more than half the hospital facilities in the area two years ago. Local construction projects range from the new multi-million dollar Montreal General Hospital to $750,000 in improvements to the Lachine General Hospital.

The new Montreal General Hospital, located on Pine Avenue, will cost $20,000,000. It will have 761 beds, compared with the present total of 641 in its central and western divisions. A nurses' home to accommodate 248 and a residence for 80 interns are also being built at the hospital.

Located on Côte Ste. Catherine road, the new Ste. Justine Hospital for children will cost $20,000,000 also. The building is expected to be ready for occupancy in 1956.

Notre Dame Hospital, with a $10,000,000 expansion program, ranks third in the current building program. It will add 500 beds to its present total of 600 and will enlarge considerably most of its departments. Completion of the work is expected within two years.

The Royal Victoria Hospital is adding 276 beds to its present capacity of 750 and other facilities are being expanded at a cost of $8,000,000.

The Montreal Children's Hospital expects to spend about $9,000,000 on a new 385-bed hospital, to be built on the site of the General Hospital's Western Division.

Work to cost $5,000,000 started recently at the Hôtel Dieu Hospital, where a new wing will add 275 beds. Further plans are also being made for other additions to the hospital, which would cost $2,000,000.

Modernization and expansion work at the Jewish General Hospital will cost $5,500,000. It will include 215 new beds and a nurses' residence.

Major projects completed include St. Joseph's Sanatorium in Rosemount; expansion of facilities at the Montreal Neurological Institute; and a new wing to the Royal Edward Laurentian Hospital.

Expansion of services are planned at the St. Luke Hospital, Ste. Jeanne d'Arc, Maisonneuve, Queen Elizabeth, St. Mary's, Reddy Memorial, and at the Bruchesi Institute. A new BCG Hospital in Rosemount is also being planned. There are further developments under construction or being planned in Lachine, Ville St. Laurent, on the south shore, and in Chambly county.

Bequest to Medical Faculty

A bequest of $500,000 to the University of Toronto Faculty of Medicine, Toronto, Ont., was made by the late Gordon Clifford Leitch. Mr. Leitch took a great interest in the university's school of medicine, particularly through his close friends of many years, the late Dr. Frederick Tisdale, and Dr. D. M. Lowe of the department of obstetrics and gynaecology. At the time of his death, Mr. Leitch was president of the board of the Toronto Western Hospital.

There is only one real failure in life; and that is not to be true to the best one knows.—*Canon Frederic W. Farrar*

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Research and Nutrition

(Concluded from page 74)

food habits and improved methods of food preparation. A survey made by Helen Mellanby in 1950 on 1,486 children in Newfoundland again emphasized this need. She suggests that more milk, eggs, fruits, fresh vegetables, and cod liver oil be included in the diet of Newfoundland mothers and children.

Improving the Nutrition of Children

In the report of Olga H. Anderson (1951), nutritional advisor to the Department of Health in Newfoundland, one learns of the sincere effort being made there by various means to improve the nutrition of the children especially. In this connection Miss Tung Yu Lin in the Department of Food Chemistry at the University of Toronto has analyzed the nutrition records and the dental health records of 282 children from Newfoundland. These were obtained from Dr. R. M. Grainger, dental statistics and research, division of medical statistics, Department of Health for Ontario, and the data were collected by Dr. K. Pownell while doing dental work in Newfoundland under the National Junior Red Cross, during the summer of 1951. The nutrition data were coded by Miss Lin and then scored, for example: milk taken irregularly was given two points and, if daily, four points. Other foods, such as meat, fish, eggs, cheese, fruits, et cetera, were given one point if taken irregularly and two points if frequently or daily, and one or two more points were subtracted for candies and pastries consumed either daily or irregularly. The data on the dental charts were also coded and scored for decayed and missing teeth. With both the primary and secondary teeth, on the average a high nutrition score accompanied good teeth. It seems evident then that the high dental caries rate found in all of the six surveys to which reference has been made can be reduced when food habits improve. Especially is this true if the intake of sweets and carbohydrates in general is reduced. In 1952, the total carbohydrate intake was reported to be 67 percent compared with 51 per cent in the U.S.A. and Canada.

Well-balanced Diet Necessary

Reference is made again to the introduction of bonemeal flour to increase the calcium content since it illustrates once more the need for caution with respect to additives to foods. Bonemeal had already been added for some time to certain baby foods. Bonemeal may contain from 300 to 700 or more p.p.m. fluorine, but on discussing this with some who were concerned with this additive it was said that this element was in a form which would not be absorbed by the body. Balance experiments, conducted in the food chemistry laboratories by Dr. Mary Ham on women and infants, showed that not only was some of this fluorine absorbed but a proportion was retained. This may or may not be a desirable condition. It would depend on the amount of fluorine being ingested from other sources. Dr. Ham also found a tea extract (five minutes steeping) contained approximately 1 p.p.m. fluorine and some of this fluorine was also found to be absorbed and retained. Weak stomach conditions are prevalent in Newfoundland and one wonders about the effect of bonemeal and fluorine on such stomachs. Flourine accumulates with age in the human skeleton and "stiff back" is one of the symptoms of bone fluorosis. However, very little work has been done yet on the minor effects of mild fluorine poisoning especially on delicate constitutions. This is just one more example of where it is wise to keep a middle course and not be carried away with one idea to the exclusion of all others.

To sum up with a general conclusion, it might be said that as each new discovery and addition to knowledge in nutrition is explored, those who learn of it use restraint, so that it is not over-emphasized out of proportion to its significance, but rather that an attempt be made to fit it into its right niche in relation to all the body metabolic processes. In other words, the importance of any one or two nutrients should not be exaggerated over the others, unless under exceptional circumstances, partly because of inter-relationships among metabolites. A balance of nutrients, to the best of our knowledge, should be maintained for over-all good nutrition.

He may be a practical man who can't bother to listen—but he is not a wise man, nor a good man, nor one who will ever be loved.

Training for Nursing Assistants in Saskatchewan

In July, 14 fully qualified nursing assistants were graduated from the Canadian Vocational Training School in Saskatoon. The course offered by the training school is sponsored jointly by the federal department of labour and the provincial department of education. A school for nursing assistants was first established at Maple Creek, Sask., in 1946. However, early in 1947 it was transferred to Saskatoon and became a larger unit. In 1953, the course was extended from a six-month to a nine-month period. Trainees now spend three months at classroom work under the supervision of a senior instructress and five and one-half months in hospitals practising bedside nursing, under the direction of a clinical instructress. During the remaining two weeks they prepare for and write examinations to qualify for their diplomas. Until this year three new courses were begun each year. However, the program is expanding and one course was begun in August, with others scheduled to start in November and January, and at 10-week intervals after that.

The first part of the course keeps the group in the lecture room, demonstration laboratory, and diet kitchen. Classes include ethics, personal and community hygiene, nursing care of the sick, anatomy and physiology, hygiene of pregnancy, care of the mother and child, care of children, nutrition and cookery, civil defence, and nursing arts. This comprehensive study of nursing theory makes nursing assistants a semi-professional group.

The portion of time spent in practical nursing is allotted to various special departments in Saskatoon hospitals. Three weeks are spent in the children's ward, three in maternity, one in the diet kitchen, one in the emergency service. The remainder of the time is divided among medical and surgical wards and wards for the aged. While in training in the hospital, uniforms and caps are provided and laundered at the school's expense. One meal per day is also provided free during hospital service. As well, for the duration of the course, these girls receive a weekly living allowance of from $6.90 to $18, depending on their family responsibilities. For example, a woman with a child receives $2.15 per day.

To qualify for this course, applicants must have as a minimum education grade eight, preferably higher, must be in good health, and be between the ages of 18 and 40, married or single. Currently, the largest age group falls between 18 and 26, and most trainees are unmarried. Successful applicants not residing in Saskatoon receive paid transportation to the school and home again following the completion of the course. Upon their arrival the school provides a list of boarding places for the students and they are placed near the school without difficulty.

School officials emphasize that only emotionally mature people are suitable for the training and that high standards are being upheld. The nursing assistants are qualified for a number of different types of positions. They may go to general hospitals, sanatoria, Red Cross blood donation stations or government nursing homes or they may become doctors' receptionists, or assume private duty. To date general hospitals have been the most popular choice. The assistants are specially prepared to care for the convalescent, the chronically sick, the aged, new mothers, and babies. But they will not begin to fill the openings available to them, as the demand for trained nursing personnel is constantly pressing—*Saskatchewan "News"*

University Scholarships

Undergraduate scholarships have been established in 18 universities and research fellowships in two universities by Union Carbide Canada Limited and its divisions. The extensive scholarship program is designed to assist able and deserving students who are interested in business or industrial careers to obtain a university education and to develop more men and women qualified for future executive and administrative positions. Each scholarship has a value to the student of $500 per year, continuing until the completion of the academic course.

The fellowships are open to graduates of Canadian universities who have demonstrated distinct evidence of ability to conduct original research. The fellowships are tenable in either the natural or social sciences and have a basic value to the fellow of $1,500. These fellowships are offered at the University of Toronto, Toronto, Ont., and McGill University, Montreal, P.Q.

Nurse Instructors
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Salary: $255-$287. per month. Eligible for registration in B.C.; post graduate training in Psychiatric Nursing, preferably teaching experience in a psychiatric hospital. Apply Personnel Officer, B.C. Civil Service, Essondale, B.C.

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Canadian, aged 37, married, excellent health, desires position of wide scope. Has well balanced education and experience gained in four hospital courses and the directorship of seven general and special hospitals. Sound application of personal qualities to knowledge has resulted in meeting hospital objectives and within financial resources. Box No. 10-59, The Canadian Hospital, 57 Bloor St. W., Toronto, Ont.

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Administrative Housekeeper, thoroughly experienced, conscientious, healthy and energetic, early fifties, exemplary references, Toronto. Returning to Canada shortly, seeks responsible position Box No. 10-62 W, The Canadian Hospital, 57 Bloor St. W., Toronto.

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News Released by Hospital Supply Houses

By C.A.E.

1955 is Centennial Year for Crane Company

You can't heat a hospital or run a railroad or build a dam, operate a paper mill or lay a sewer, dig an oil well, launch a battleship, or even take a shower without using one of the 40,000-odd products that are made by the Crane Company. Their function is to control the flow of gas and oil and water, air and steam—the volatile spirits that drive and heat and bathe the power-packed world of today. Specifically, Crane manufactures the valves that turn those elements on and off; fittings for the pipe that conveys them; and the pumps that draw them out of the earth.

On July 4th, 1955, Crane Co. will observe its 100th birthday. The centennial will be celebrated at the central office in Chicago, as well as in plants, branches, and subsidiaries during the entire calendar year, 1955, with special events of national significance. The company began on July 4th, 1855, when 23-year old Richard Teller Crane, the founder, opened a one-room, self-built shop in Chicago, population 75,000.

Crane Co.'s rise from humble beginnings a century ago to a multi-million dollar corporation with sales of more than 315 million dollars in 1953 is a typical American success story. The company began by supplying a modest quality product—brass lightning rod tips—to a small, local market. It has grown with the city and the nation to a point in its career where the 40,000 Crane products are used in factories, institutions, farms, offices, and homes throughout the continent.

The company employs approximately 17,500 persons in the United States. Its subsidiaries in Canada and England combined employ approximately 5,000 persons. Crane Co. is believed to be the first corporation in the United States to establish a medical department for employees.

Davis & Geck Introduces New Package

Davis & Geck, manufacturers of sutures and surgical specialties, has introduced a new Measuroll Anacap silk package which saves time, work and costs for hospitals. Measuroll is the latest of D & G's five convenient Anacap silk packages.

The new Measuroll package, which comes in a convenient dispenser box, is a 10-yard paper tape which serves as a wrapper for 20 strands of Anacap silk. Inch markings are printed on the tape to guide the cutting, and the nurse can cut 20 strands at a time, any lengths specified by the surgeons.

The paper wrapper for the sutures protects them through autoclaving, and keeps them sterile until use. It also identifies the size and the name of the product up to the time the sutures are used.

On request from hospitals, Davis & Geck will send a sample of Anacap silk in specified size, cut from Measuroll. Anacap silk is smooth, strong, flexible, non-capillary. Greater tensile strength, because of more silk per suture, permits use of smaller sizes, a factor in faster wound healing. Anacap silk has continued strength after many sterilizations. Davis & Geck,, Inc., a unit of American Cyanamid Company, Danbury, Connecticut, inites you to write for sample referred to.

New Cutter Solutions

Three new multiple electrolyte solutions supplementing Polysal—the original balanced electrolyte solution—have been added to the growing list of Cutter products for electrolyte therapy.

These solutions, Cutter Electrolytes Nos. 1, 2, and 3, are designed for the doctor to provide electrolytes in accordance with needs for specific therapy and are not patterned after the electrolyte composition of plasma. All three solutions contain invert sugar 10 per cent, providing 400 calories per liter and may be administered either intravenously or subcutaneously.

With Cutter Electrolyte No. 1, the lactate and sodium have an alkalizing action which is usually sufficient to correct mild acidosis. Cutter Electrolyte No. 2 (Butler's Formula) is recommended as a routine maintenance solution for patients with essentially normal kidney function. It has the advantage that sodium and chloride are low, while potassium and phosphate are high. Cutter Electrolyte No. 3 (Cooke and Crowley's Formula) is patterned after the average composition of gastric secretions and is intended for replacement of fluid lost through gastric suction or vomiting.

Edwards of Canada Issues Catalogue

Edwards of Canada Limited have commenced distribution of their new catalogue on electrical signalling, communication and protection equipment.

The new leather-bound catalogue is fully illustrated with comprehensive information, diagrams and technical data on the complete Edwards line. Included is the Edwards centrally-controlled clock and programme systems for hospitals, schools, colleges, public buildings and industry; and also the Edwards hospital signalling systems, fire alarm systems and communication systems.

This is the most complete catalogue ever issued by this firm. A request to Edwards of Canada Limited, Owen Sound, Ontario, will bring the catalogue by return mail.

(Concluded on page 140)

Across the Desk

(Concluded from page 138)

Dunlop's New Pillofoam Plant

A multi-million dollar expansion program by Dunlop Tire and Rubber Goods Company Limited, now going forward at Whitby, Ontario, will include immediate construction of a new Pillofoam cushioning plant, J. P. Anderson, President and General Manager, has announced.

M. R. Mallory

The new plant will be the second Dunlop factory located on the company's 56-acre Whitby property.

The new Pillofoam plant will make possible a substantial increase in the company's output of its cushioning products, Mr. Anderson stated. It will house the most modern equipment for the production of latex foam including newly developed automatic machinery.

To direct an expanded sales force the company has appointed Malcolm Ross Mallory as Sales Maager of its Pillofoam Division. A native of Saskatchewan, he attended the University of Toronto and saw service during World War II as a lieutenant in the Royal Canadian Artillery.

Colson Opens Plant in Canada

Colson (Canada) Limited, a subsidiary of The Colson Corp., of Elyria, Ohio, is starting manufacturing operations at 65 Manser Road near the Barrie Highway in Toronto.

The parent firm is a pioneer in rubber-tired equipment for hospitals and produces a complete line of hospital equipment, casters and materials-handling equipment for industrial and institutional use.

The company has been selling in Canada for several years and has established a subsidiary here to participate in the great economic development taking place, R. A. Pritzker, president, states.

The Canadian subsidiary will be managed by Roy D. Hill, vice-president and general manager and Edward A. Foley, vice-president and sales manager.

Seamless "Stopperless" Bottles in Green and Red

Now the Original Seamless "stopperless" combination hot water bottle and ice bag comes in both red and green. "Stopperless", the first of the strap-neck bottles features trouble-free performance. There are no washers, threads, stopples or chains in the unit. The extra-wide mouth accommodates ice cubes as well as water. Addition of the green "stopperless" is in response to hospital requests as different colours are found to be helpful for ward identification.

For further information write The Seamless Rubber Company, New Haven 3, Connecticut.

C-I-L Odourless Paints

A major advance in paint technology has been made by the paint and varnish division of Canadian Industries (1954) Limited by the introduction of odourless alkyd enamels for interior use on walls and woodwork.

These products were developed by the company's own paint scientists and are being released under the trade name "Ciltone". They are available in three sheens—flat, semi-gloss and gloss. The flat finish is said to have greatly improved washability and can be used without a sealer.

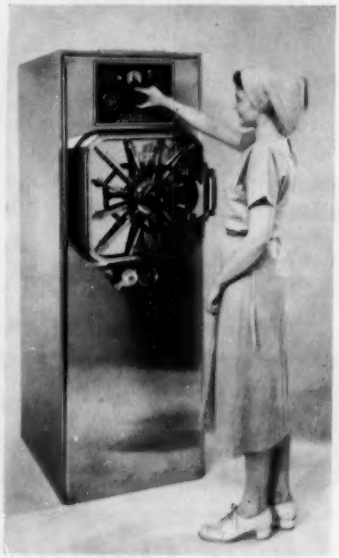
These odourless enamels are ideal for hospital use as the characteristic odour usually associated with interior paints has been eliminated.

The new finish is available in 21 different colours: including vista green, ivory, sunshine, dusky rose, spring green, ocean green, horizon blue, royal red, court chartreuse, chevron blue, castle grey, pageant red, herald yellow, commonwealth green and white.

This advance in paint manufacturing has been made possible by the recent development of odourless solvents by the petroleum industry.

American Sterilizer Announces New Line

The American Sterilizer Company announces a complete new line of sterilizing equipment . . . The American square sterilizer, the design with a 35%-100% increase in usable sterilizer capacity (depending upon type of load) compared with the conventional cylindrical sterilizer counter-parts.



American "Square" Sterilizer

This tremendous increase in sterilizer loading capacity is, it is claimed, fundamentally a labour-saving device. By increasing the loading capacity of the sterilizer without increasing the maintenance burden or occupied floor space, the sterilizer operator makes fewer trips to the sterilizer to load, unload, and then reload the machine for an additional cycle.

The square sterilizer will be available in the recessed mounting as well as the new cabinet mounting. The new American Sterilizer stainless steel cabinet may be used wherever open-mounted equipment is normally installed. It reduces heat, saves floor space, enhances appearance, and economizes on installation expense thereby combining the advantages of recessed equipment and open-mounted equipment without the disadvantages. A complete line of sizes and types of sterilizers is available in this new square design. Write for Catalogue C-162, American Sterilizer Company, Dept. SS, Erie, Pa.

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Nature Sanitizes the Hippo...

Wood's Sanitizes the Nation

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